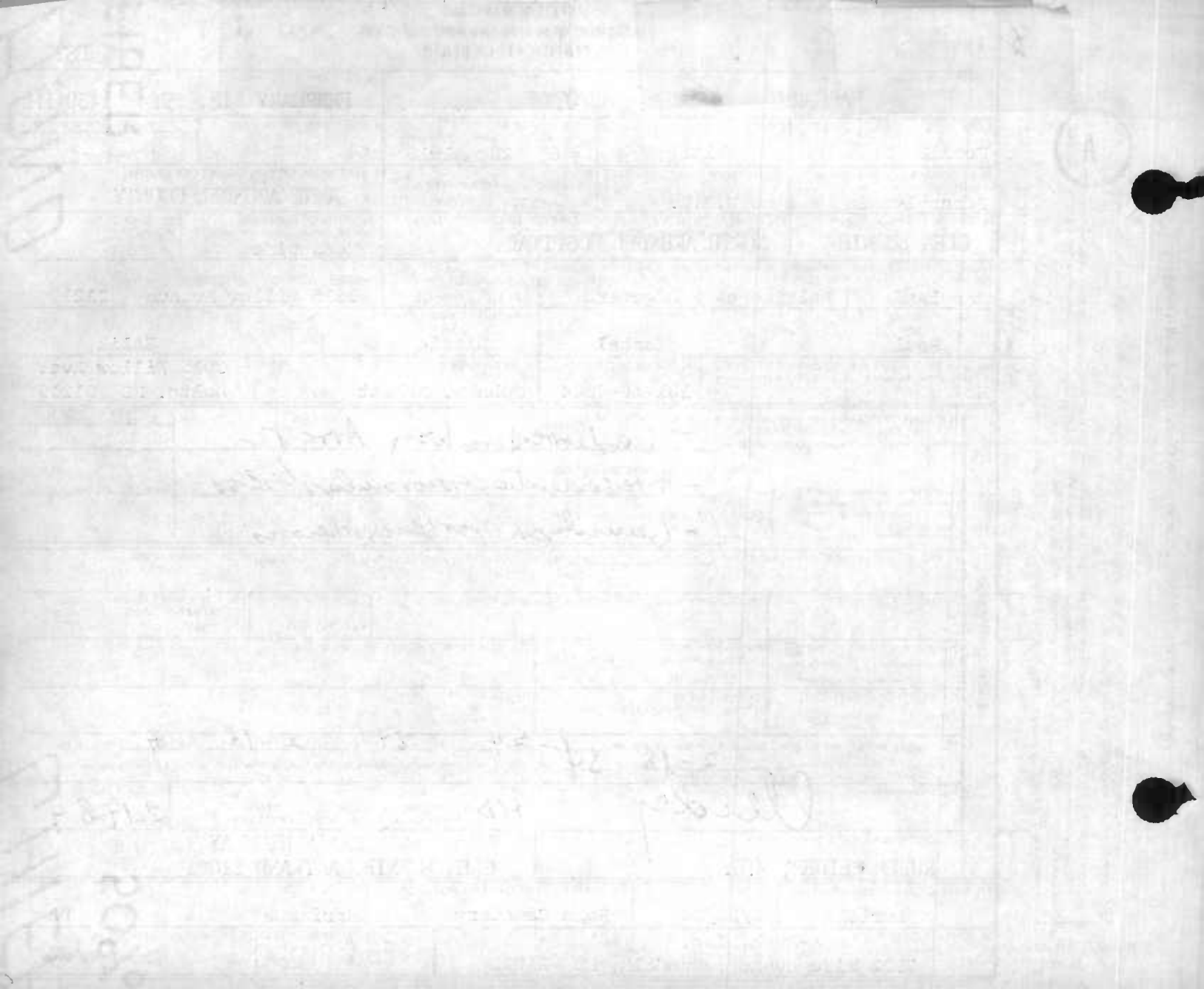


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.		EST	
1. FOR STATE REGISTRAR				2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET ABBOTT				FEBRUARY 18, 1984		430 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 28 1919		6. AGE (IN YEARS (LAST BIRTHDAY)) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Moskal				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Galik			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 181-40-6064		17. INFORMANT ADDRESS John R. Abbott 3015 Willow Avenue. Balto. MD 21219	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - <i>Cardiorespiratory Arrest</i> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) - <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) - <i>Generalized arteriosclerosis</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-18-84</u> to <u>2-18-84</u> , that (I) (we) lost saw the deceased alive on <u>2-18-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Rubén Reider</i>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-19-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDER, M.D.				22e. ADDRESS 1406 CRAIN HIGHWAY GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/23/84		23c. NAME OF CEMETERY OR CREMATORY Horn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marianna PA	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE <i>Richardson-Randell</i>	
2722 Wise Avenue, Dundalk, MD 21222							



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03142

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
James Charles ALLISON, SR.			February 1 - 1984			11 A M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
male		white		April 5, 1916		67		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
PA.		USA				AA Co. MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY	
Glen Burnie			6509 D South Charter Rd.			elect. eng. (ret)			Westinghouse	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS, ZIP CODE		
MD		AA		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6509 D South Charter Rd. 21061		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
William Allison				Bertha Jones						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO			XXXXXXXXXX		Balt. MD 21227					
			163/07/0310		A Bernadine Bricker (daughter)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Ventricular arrhythmia</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Bhasant Khardelwal</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bhasant Khardelwal					22e. ADDRESS 7422 B & A Blvd. Glen Burnie, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			Feb. 3, 84		Glen Haven Mem Pk		Glen Burnie AA MD			
24. FUNERAL DIRECTOR NAME <u>ARB</u> ADDRESS					25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					
Singleton Funeral Home, Glen Burnie, MD					FEB 3 1984 <u>John J. Smith</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

411



10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) WILLIAM A ANDRYSIAK			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 07, 1984		2b. HOUR PM 430
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 2-6-1916	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Tec.		12b. KIND OF BUSINESS OR INDUSTRY Electroni
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY A.A.Co.	13c. CITY OR TOWN Ferndale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 8 Eugenia Ave. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST James Frank Andrysiak		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida - Jaworski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W.II		16b. SOCIAL SECURITY NO. 217-01-6182A		17. INFORMANT ADDRESS Irene Mary Andrysiak 8 Eugenia Ave 21061	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1623 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Cancer of the Lung					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/23/84 , 19 84 , to 2/7/84 , 19 84 , that (I) (we) last saw the deceased alive on 2/7/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gelsimo A. Cruz		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GELSIMO A. CRUZ, M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 847 COASTAL DRIVE ANNAPOLIS, MARYLAND 21401	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-10-84	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie (A.A.), Md.
24. FUNERAL DIRECTOR NAME Raymond C. Fink		ADDRESS Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR FEB 8 1984	
				25b. REGISTRAR'S SIGNATURE John J. Connel	

BP

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11-2-01

• 128 •

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[REDACTED]

John Brown, 1811-1859

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FLORENCE L. ANGELINE				2a. DATE OF DEATH MONTH FEB. DAY 2 YEAR 1984			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH 8 DAY 30 YEAR 1929		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH CROWNSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 400 Alder Trail		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 400 Alder Trail		13f. CITY OR TOWN 21032		14. FATHER'S NAME FIRST Arthur MIDDLE Kluth LAST Hilda		15. MOTHER'S MAIDEN NAME FIRST Hilda MIDDLE Bialas LAST Bialas	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean		17. INFORMANT Donna Angeline		ADDRESS same as 13 e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1919 IMMEDIATE CAUSE (a) globlastoma - primary brain tumor DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (g)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/25/83 , 19____, to 4/2/84 , 19____, that (I we) lost saw the deceased alive on 1/10/84 , 19____, and that in (my our) opinion death occurred on the date and hour and from the causes stated above, (I we) (did not) view the body after death.							
22b. SIGNATURE Stanley Watkins				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WATKINS, STANLEY				22e. ADDRESS 51 Franklin St., Annapolis, Maryland 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 8, 1984		23c. NAME OF CEMETERY OR CREMATORY Servicemans Cemetery		23d. LOCATION CITY OR TOWN Mitchell COUNTY South Dakota STATE	
24. FUNERAL DIRECTOR NAME Beall Funeral Home ADDRESS 16000 Annapolis Road Bowie, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 10 1984		25b. REGISTRAR'S SIGNATURE John J. Connelley	

BP _____



WAVE

2000-00-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and signed.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Robert Joseph Auditori		MONTH DAY YEAR HOUR February 3 1984 1:20 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	CAU	MONTH DAY YEAR Feb 2 1944	YRS. MONTHS DAYS HOURS MIN. 40
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.A.		Anne Arundel County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ft. Meade, Md.	Kimbrough Army Community Hospital		Logistitian
12b. KIND OF BUSINESS OR INDUSTRY		12c. USUAL OCCUPATION	
US Govt. NSA		Logistitian	
13a. COUNTY		13b. CITY OR TOWN	13c. STREET ADDRESS
Maryland	Anne Arundel	Annapolis	290A Hilltop Lane 21403
14. FATHER'S NAME FIRST MIDDLE LAST Alfonso Auditori		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Cost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT ADDRESS	
No	205-32-2715	Wife/Ruthann/290A Hilltop Lane, Annapolis, Md. 21403	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. certify that (I) (this hospital) attended the deceased from 3 Feb , 19 84 , to 3 Feb , 19 84 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 3 Feb , 19 84 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Frank Miles		22c. DATE SIGNED 3 Feb 84	22d. ADDRESS Maryland
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Frank Miles, Cpt, MC		22f. ADDRESS Kimbrough Army Community Hospital, Ft. Meade/	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Feb 6, 1984	Hillcrest	Annapolis, MD
24. FUNERAL DIRECTOR NAME		24b. ADDRESS	
Taylor Funeral Chapel - Annapolis, MD		EEBO 61984	

February 2 1981 1:30P

Amidst

Joseph

Robert

Male

CU

Feb 2 1981

AD

AD

Anne Arundel County

U.S.A.

Pennsylvania

US Govt. NSA

Postmaster

Blacksburg Army Community Hospital

Pt. Mable, W.

200A Hilltop Lane #1113

Anne Arundel Annapolis

Stacyland

Cost

Admission

Admission

Alfonso

200-21-1113 - 200A Hilltop Lane, Annapolis, MD

200-21-1113

20 minutes

London Avenue

at

2 Feb

BA

2 Feb

2-11

2 Feb 81

Postmaster

Blacksburg Army Community Hospital, Pt. Mable

Pt. Mable, W.

200-21-1113 - 200A Hilltop Lane, Annapolis, MD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03146

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WILLIAM F AUTREY			2a. DATE OF DEATH MONTH DAY YEAR 02-13-84			2b. HOUR 0822 M.			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 02 11 10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mailman		12b. KIND OF BUSINESS OR INDUSTRY Postal Ser.	
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Shady Side		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4996 Lerch Dr. 20764	
14. FATHER'S NAME Montgomery Patrick Autrey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 31-33		17. INFORMANT Charlotte B.		ADDRESS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatoid arthritis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs 16 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/11 , 19 84 , to 2/13 , 19 84 , that (I) (we) lost saw the deceased alive on 2/13 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Breisen			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/13	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 17, 1984		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Md.		
24. FUNERAL DIRECTOR NAME T.A. Hardesty			ADDRESS Ann. Md. 21401			25a. DATE REC'D. BY REGISTRAR FEB 15 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and all entries on this form must be signed by the medical examiner.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03147

1- FOR
STATE
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) JACOB MAX BADWAK			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 10, 1984			2b. HOUR 154 AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mng. Const. Equip. Rental Co.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Orchard Beh.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1003 Fieldstone PL 21226			
14. FATHER'S NAME FIRST MIDDLE LAST Unk. Unk.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mantha Badwak							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE YEAR OR DATES) Yes 53-60		16b. SOCIAL SECURITY NO. 213-32-8678		17. INFORMANT Nancy Badwak same as 13 E				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Recep Erol M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RECEP EROL M.D.						22e. ADDRESS 325 HOSPITAL DRIVE GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-13-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cent.			23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk. A.A. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Mc Cully Funeral Home 3204 Mountain Rd. 21122						25a. DATE REC'D. BY REGISTRAR FEB 14 1984					
						25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

The medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

FILED
FEB 23 1950
X
CLERK OF COURT

UNITED STATES OF AMERICA
vs.
JOHN EDGAR HOOVER

Defendant
No. 1003
Indictment No. 1003
March 1950

Case No. 1003
FEB 23 1950

UNITED STATES OF AMERICA
vs.
JOHN EDGAR HOOVER

Defendant
No. 1003
Indictment No. 1003
March 1950

Case No. 1003
FEB 23 1950

UNITED STATES OF AMERICA
vs.
JOHN EDGAR HOOVER

Defendant
No. 1003
Indictment No. 1003
March 1950

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03148

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE Andrew BAER			2a. DATE OF DEATH MONTH DAY YEAR 2-14-84		2b. HOUR 2:45 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1-02-06		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL Co MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL General Hospital & L		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Ret.) Dept. Agr.		12b. KIND OF BUSINESS OR INDUSTRY Civil Service
13a. STATE MD			13b. COUNTY AA Co	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Ernst Frederick Baer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth H. Schaefer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 17a-05-6738		17. INFORMANT ADDRESS Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **pulmonary Embolus**
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) **Resection of lung cancer**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF
(c) **COPD**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Rheumatoid Arthritis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>Jack R. Lichtenstein</i>	DEGREE MD	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack R. Lichtenstein, MD	22e. ADDRESS 20 Ridgely Ave, Annapolis, MD 21401	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Feb 15, 1984	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. MD
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis, MD		25a. DATE REC'D BY REGISTRAR FEB 15 1984	
		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendell</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP _____

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elizabeth Anna Bassett</i>					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>2 14 84 9:00 PM</i>				
3 SEX <i>Female</i>		4 RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4-24-21</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>62</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto., Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Glen Burnie (A.A.)</i> MD.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4105 Hollins Ferry Rd.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>A.A. Co.</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>4105 Hollins Ferry Rd.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John - Kramer</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anne - Segel</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>					16b. SOCIAL SECURITY NO. <i>215-14-0240</i>		17. INFORMANT ADDRESS <i>Oyster House Rd. Brooms Island, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1d</i> <i>10 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Breast Cancer</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1-28</i> 19 <i>84</i> to <i>2</i> 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>1-28</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i> DEGREE <i>M.D.</i>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2-15-84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Long S. Hsu</i>					22e. ADDRESS <i>4922 Ten Mills Road, Columbia Md 21044</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2-18-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>O'Donnell St. Balto., Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Raymond C. Fink</i>					ADDRESS <i>Glen Burnie, Md.</i>		25a. DATE REC'D BY REGISTRAR <i>FEB 16 1984</i>		
					25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				



RECEIVED



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 03150

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GUY F BISHOFF			2a. DATE OF DEATH MONTH DAY YEAR Feb. 9, 1984		2b. HOUR MIN. 1050 P						
3 SEX M.		4 RACE W.		5 DATE OF BIRTH MONTH DAY YEAR 10 28 11		6 AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Aurora W, Va		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County A.A. MD.					
10 CITY OR TOWN OF DEATH Baltimore, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crownsville				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book-Keeper		12b. KIND OF BUSINESS OR INDUSTRY S.P.			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3504 Elliott St. 21224			
14 FATHER'S NAME FIRST MIDDLE LAST George B Bishoff				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Berdie Nester							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 236 14 8910		17 INFORMANT ADDRESS Mrs. Gay Bishop 3504 Elliott St 21224					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease yes DUE TO, OR AS A CONSEQUENCE OF (c) organic mental disorder with senile dementia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): organic mental disorder with senile dementia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/23/84 , 19____ to 2/9/84 , that (I) (we) last saw the deceased alive on 2/9/84 at 1050 pm , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE I.A. ORER MD.						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) I.A. ORER						22e. ADDRESS Crownsville					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/13/84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md			
24. FUNERAL DIRECTOR NAME Walter Dabrowski						ADDRESS 1005 Dundalk Avenue		25a. DATE REC'D. BY REGISTRAR FEB 15 1984		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

March 19, 1944

Calicut, India

Dear Sir,

Thank you for your letter of the 14th inst.

March 19, 1944

Calicut, India

Dear Sir,

I have received your letter of the 14th inst.

March 19, 1944

Calicut, India

Dear Sir,

I have received your letter of the 14th inst.

and in reply I am sorry to hear that you are not well.

Yours faithfully,

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

W. J. S. (Signature)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with you 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Doris K. Bogy			2a. DATE OF DEATH MONTH DAY YEAR Feb. 3, 1984		2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 23, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A.Co. MD.
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital,		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY A.A.Co.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George ---- Gordon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha ---- Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 217-05-4292		17. INFORMANT ADDRESS Mr. William V. Bogy, Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute CORONARY Artery Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>2 hrs</u> <u>YEARS</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>NO</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/13</u> 19 <u>83</u> , to <u>2-3</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>10-13</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Marcelino F. Albuverne</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/6/84</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARCELINO F. ALBUVERNE MD</u>		22e. ADDRESS <u>1940 W. BALD ST BALD MD 21223</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Feb. 6, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>McCutty Funeral Home, Mt. & Tice Neck Rds. Pasadena, Md. 21122</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 6 1984</u>				
25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Georgianna Ann Boston				2a. DATE OF DEATH MONTH DAY YEAR 2-14-84			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 27 1898		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Adco MD	
10. CITY OR TOWN OF DEATH Anne		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Jail		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY HARCO		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Holmes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgina Gibson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 214-05-2567		17. INFORMANT T. Norwood Brown		ADDRESS ANNAPOLIS, MD 1951 Forest Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis with Chronic CHF DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)							

1. Severe Decubiti of both heels @ DSD @ SP with @ home

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

19c. AUTOPSY? YES ☐ NO ☒19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22. I certify that (I) (this hospital) attended the deceased from **1-24-84** to **2-14-84**, that (I) (we) last saw the deceased alive on **2-13-84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE **Errol A. Phillips** DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED **2-14-84**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **ERROL-A-Phillips MD**

22e. ADDRESS **20 Ridgely Ave. Annapolis, MD 21401**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE **Feb 17-1984**

23c. NAME OF CEMETERY OR CREMATORY **Pine Lawn**

23d. LOCATION CITY OR TOWN COUNTY STATE **ANNAPOLIS A.A. MD**

24. FUNERAL DIRECTOR NAME

24a. **D.E. Hicks** ADDRESS **1922 Forest Drive**

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE **John Davidson-Randell**

FEB 21 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
George A. Bottner				2-15-84 3a M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
male		White		3-11-12		71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MD		USA				Anne Arundel MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel General Hosp.		Contractor		Construction	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MD		AA		Gambrells		21054	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE			
Frederick Bottner		Theresa Feneberg		2387 Davidsonville Rd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, PLACE UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-12-0261		17. INFORMANT ADDRESS		Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2028 Malignant Lymphoma		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/13 19 84, to 2/15 19 84, that (I) (we) last saw the deceased alive on 2/13 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE E. W. Cole MD		22c. DATE SIGNED 2/15/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. W. COLE		22e. ADDRESS 51 FRANKLIN ANNAP. MD 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 18, 1984		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR FEB 15 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

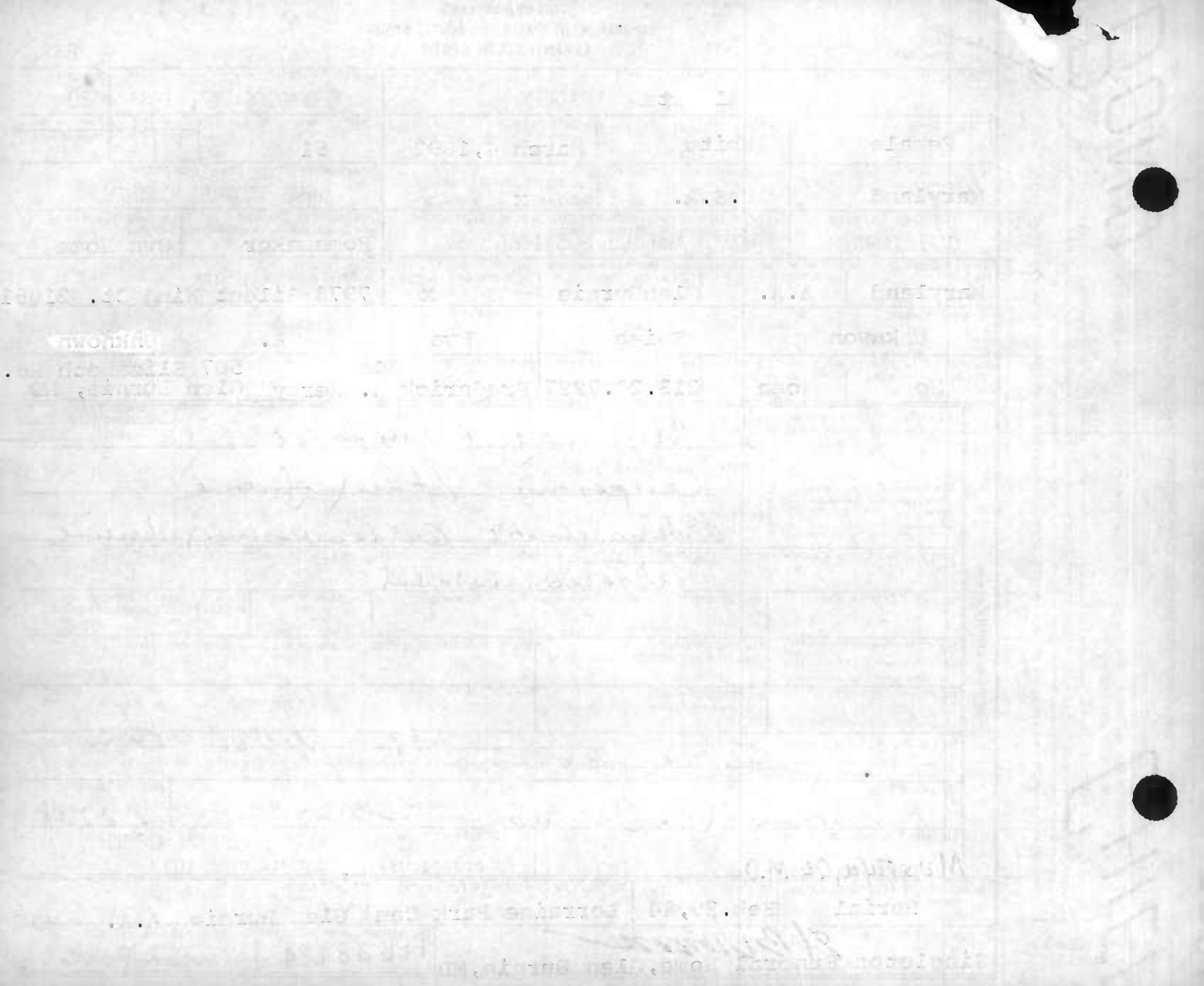
03154

1. FOR STATE REGISTRAR		REG. NO.		EST	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALMA Alverta BRADNEY			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 27, 1984		2b. HOUR 520 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 4, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland			13b. COUNTY A.A.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Spies			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva E. Kaiser		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None		16b. SOCIAL SECURITY NO. 213.20.7997		17. INFORMANT Son ADDRESS 507 Elizabeth Rd. Frederick A. Kerby Glen Burnie, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 83 to Feb 26, 19 84, that (I) (we) lost saw the deceased alive on Feb 26, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mustafa C. O2 MD 22c. DATE SIGNED 2 27 84				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mustafa C. O2 MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 29, 84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD		23e. ADDRESS CROWNSVILLE HOSPITAL CENTER CROWNSVILLE, MARYLAND 21032			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall	

Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the funeral director and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be buried with the deceased within 72 hours after death. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

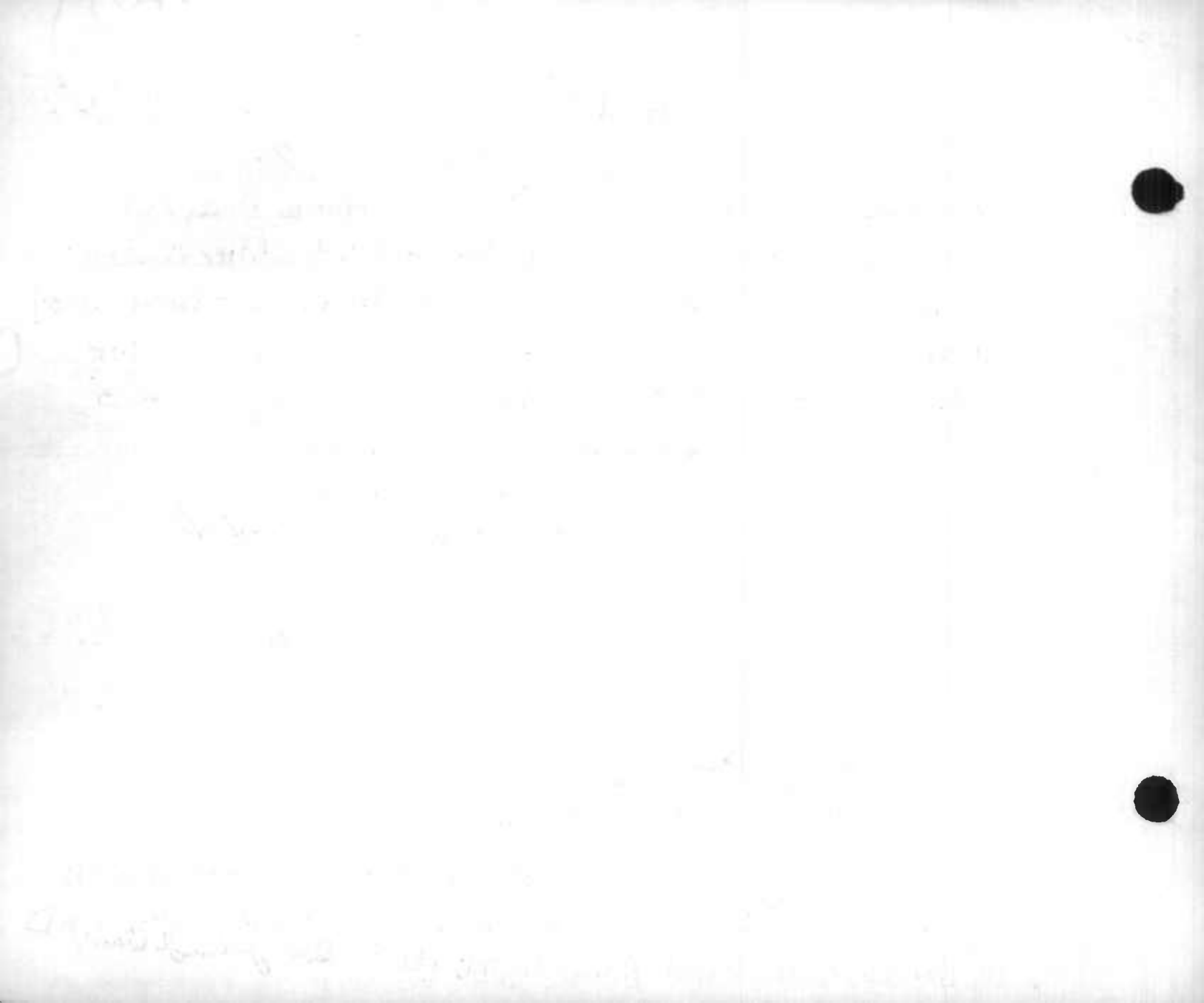
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William Wellford BRAGG			2a. DATE OF DEATH MONTH DAY YEAR 2 6 84			2b. HOUR 12 30 P.M.			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 8 12		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rel. Steamfitter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Egewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1104 Grant Drive 21037	
14. FATHER'S NAME FIRST MIDDLE LAST William Samuel Bragg				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Elizabeth Tyler					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO IF UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Dorothy C. Bragg			ADDRESS Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) dehydration - malnutrition 1850 DUE TO, OR AS A CONSEQUENCE OF (b) neoplastic disease DUE TO, OR AS A CONSEQUENCE OF (c) adenocarcinoma prostate APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) sign this body after death.									
22b. SIGNATURE <i>Theodore G. Osius</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Theodore G. Osius				22e. ADDRESS 100 Ridgely Ave., Annapolis, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Feb 7, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD				25a. DATE REC'D. BY REGISTRAR FEB 8 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03150

1. FOR STATE REGISTRAR		REG. NO.		EST	
1. DECEASED NAME (TYPE OR PRINT) LORETTA B CALDWELL			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 20, 1984		2b. HOUR 1050 PM
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR FEB 10 95		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena
14. FATHER'S NAME FIRST MIDDLE LAST — — Itelmung			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-18-6356B		17. INFORMANT ADDRESS Mrs. Leona Hyde 4931 Mountain Rd Pasadena MD 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) CUA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anemia Dehydration					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> NEAR HOME <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/10/84 19 to 2/20/84 19, that (I) (we) last saw the deceased alive on 2/20/84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I am a doctor and not a nurse, I must sign this certificate.)					
22b. SIGNATURE Dr. J. Ramirez M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/21/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-23-84		23c. NAME OF CEMETERY OR CREMATORY Glen Burnie, Maryland 21061	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		23e. DATE REC'D. BY REGISTRAR FEB 27 1984			
24. FUNERAL DIRECTOR NAME Robert J. Baranuco		ADDRESS Suena Park		25. REGISTRAR'S SIGNATURE John Davidson-Rodriguez	

STANDARD FORM NO. 64
OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315
DATE: 10/10/64
TO: THE SECRETARY OF THE ARMY
FROM: THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

1. [Illegible]
2. [Illegible]
3. [Illegible]
4. [Illegible]
5. [Illegible]
6. [Illegible]
7. [Illegible]
8. [Illegible]
9. [Illegible]
10. [Illegible]

11. [Illegible]
12. [Illegible]
13. [Illegible]
14. [Illegible]
15. [Illegible]
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17. [Illegible]
18. [Illegible]
19. [Illegible]
20. [Illegible]

21. [Illegible]
22. [Illegible]
23. [Illegible]
24. [Illegible]
25. [Illegible]
26. [Illegible]
27. [Illegible]
28. [Illegible]
29. [Illegible]
30. [Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

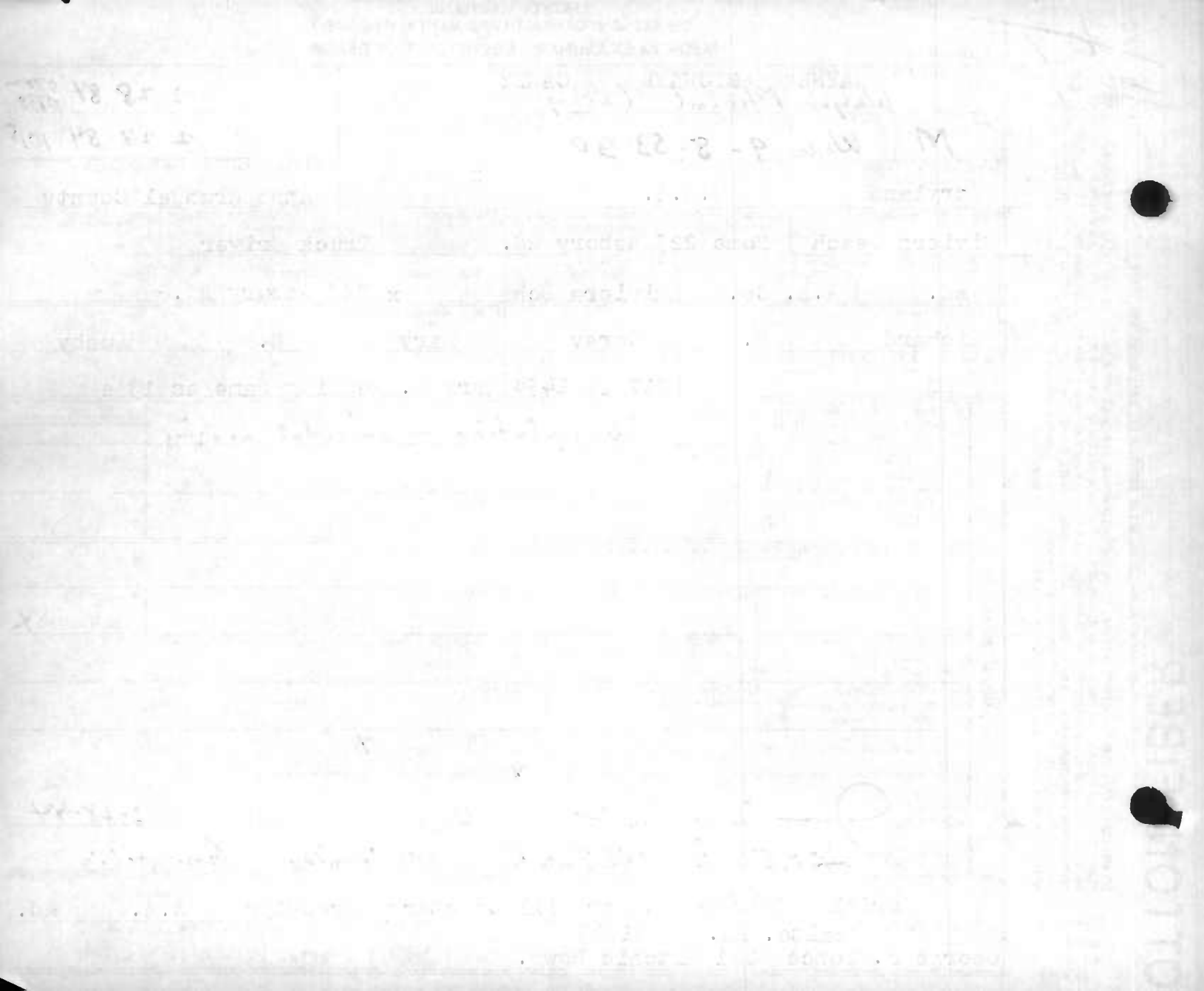
DHMH - 17
(VR A15 ME (5))
20M 4/B2

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WAYNE MICHAEL CAREY <i>Wayne Michael Carey</i>				2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 2 28 84 2b. HOUR 0830			
3. SEX M	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9-8-53	6. AGE (IN YEARS) LAST BIRTHDAY 30 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 28 84	7d. HOUR 1015
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Riviera Beach		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home 225 Asbury Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.				13b. CITY OR TOWN A.A. Co.	13c. CITY OR TOWN Riviera Bch	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 225 Asbury Rd. 21140	
14. FATHER'S NAME FIRST MIDDLE LAST Richard F. Carey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Lusby			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217 62 2454		17. INFORMANT ADDRESS Mary E. Redding same as 13 e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spangulation - suicidal hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James E Wheeler</i>		TITLE (SPECIFY) M.D. <i>Dep</i>		MEDICAL EXAMINER		DATE SIGNED 2-28-84	
EXAMINER'S NAME (TYPE OR PRINT) JAMES E WHEELER		ADDRESS 910 Primrose Annapolis					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/2/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce 4001 Ritchie Hgwy. Balto. Md. 21225				25a. DATE REC'D. BY REGISTRAR MAR 1 1984		25b. REGISTRAR'S SIGNATURE <i>Lelia Davidson</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

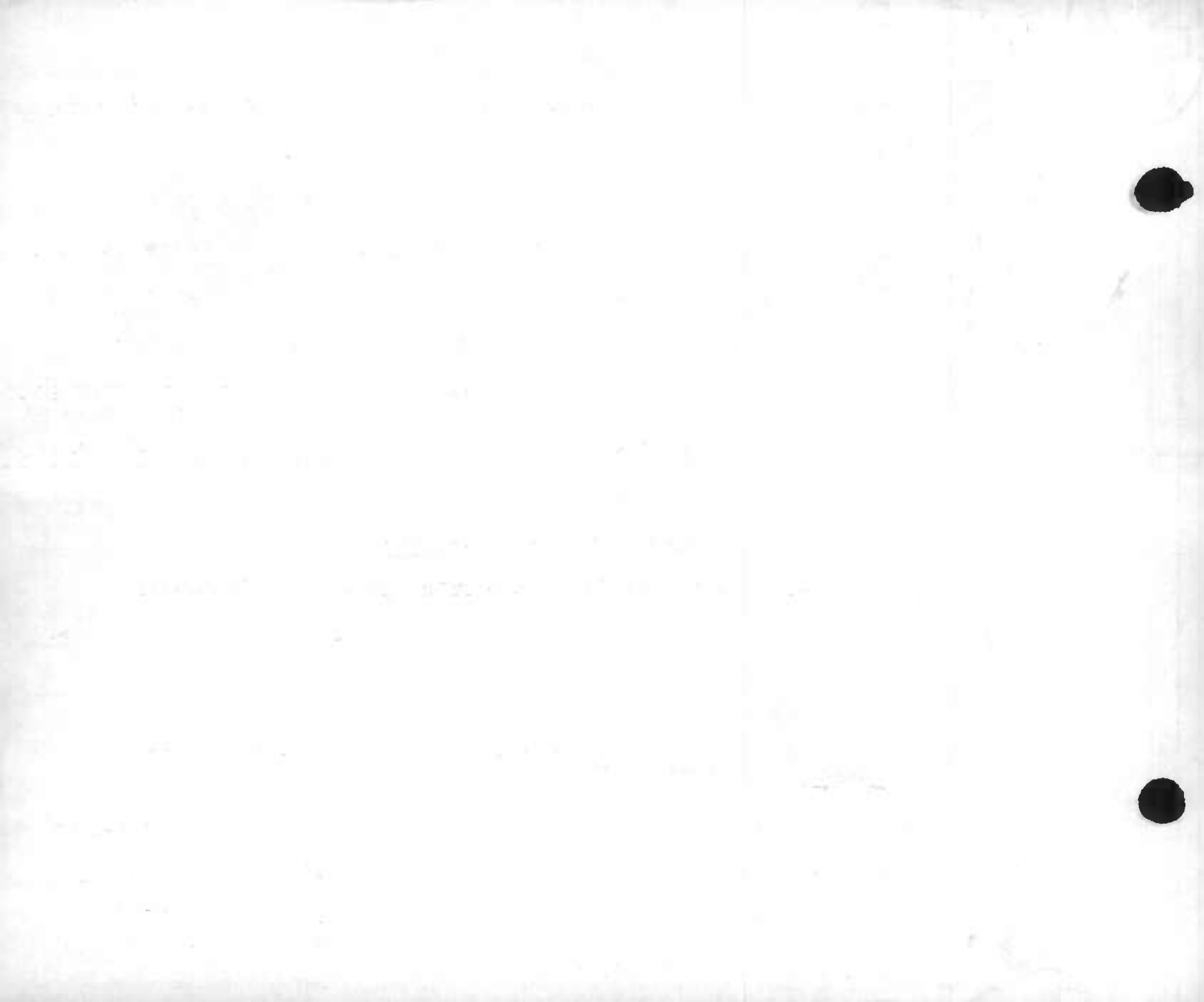
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 03158

1. DECEASED NAME (TYPE OR PRINT) JAMES E CARTER			2a. DATE OF DEATH MONTH DAY YEAR 2 26 84			2b. HOUR 9 ¹⁰ P. M.				
3. SEX M ALE		4. RACE W HITE		5. DATE OF BIRTH MONTH DAY YEAR 10 27 19		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OFFICE REPAIRMAN		12b. KIND OF BUSINESS OR INDUSTRY C&P CO.		
13a. STATE MARYLAND					13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN EDGEWATER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME ERNEST R. J. CARTER, SR.					15. MOTHER'S MAIDEN NAME MARY E. HAIGHT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII 577-22-9988		17. INFORMANT ADDRESS MICHAEL H. CARTER 2745 RIVERVIEW DR. RIVA, MARYLAND 21140						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA 5712 DUE TO, OR AS A CONSEQUENCE OF (b) LAENNEC'S CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC ALCOHOLISM 2-3 days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) INTESTINAL OBSTRUCTIVE DISORDER, DIABETES MELLITUS										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2/23 19 84 to 2/26 19 84, that (I) (we) lost saw the deceased alive on 2/26 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE A. Calabrese MD		DEGREE				22c. DATE SIGNED 2/26/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A J CALABRESE MD		22e. ADDRESS 2510 RIVA Rd #222 ANNAPOLIS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-29-84		23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VETERANS		23d. LOCATION (CITY OR TOWN) CROWNSVILLE COUNTY STATE				
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS ANNAPOLIS, MARYLAND						25a. DATE REC'D. BY BALTIMORE REGISTRAR'S OFFICE MAR 1 1984				



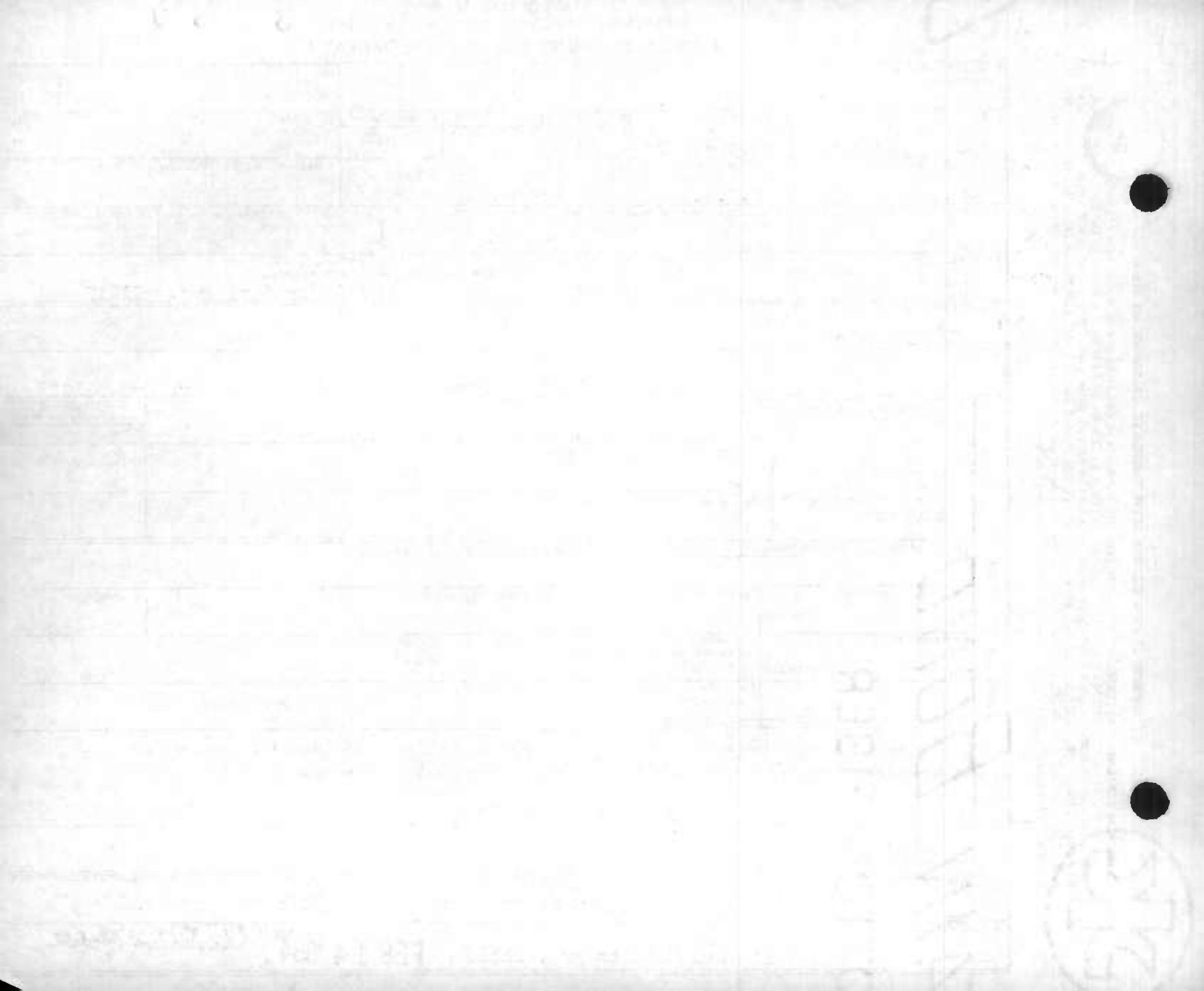
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (1))
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										3159	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)						FIRST		MIDDLE		LAST	
George N. Coles											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		20. DATE KNOWN OF DEATH ESTI-MATED MONTH DAY YEAR	
Male		Black		Sept 9, 1929		54 YRS.				2 6 19 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		24. HOUR		25. HOUR	
Va.		U.S.A.				Anne Arundel County, MD.		11:02 a		M	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Jessup				Maryland House of Corrections							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md/				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5334 Beaufort Ave. 21215			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Edward Coles				Everlean Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
-----0-----				230-30-7121		Joseph Fisher, 5334 Beaufort Ave. 21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Thomas D. Smith, M.D.				Deputy Chief				2/7/84			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Thomas D. Smith, M.D.				111 Penn St. Balto, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				2/11/84		Mt Auburn Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Law Funeral Home 4611 Park Heights Ave. 21215						FEB 14 1984		John Davidson-Randall			

MEDICAL CERTIFICATION



1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) EDNA Marie COOKE			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 19, 1984			2b. HOUR 558 PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 8, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		12b. KIND OF BUSINESS OR INDUSTRY PBX		
13a. STATE Md.			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1902 Cedar Rd. 21122	
14. FATHER'S NAME FIRST MIDDLE LAST LINK.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LINK.			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.				
16b. SOCIAL SECURITY NO. 160-16-1178			17. INFORMANT ADDRESS John E. Cooke same as 13 E							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic cardiovascular Disease (c) Renal Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Ca of Bladder - anemia -										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb 14 1976 , 19 84 , to Feb 19 1984 , that (I) (we) last saw the deceased alive on Feb 14 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Benito Martinez						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO MARTINEZ, M. D.						22e. ADDRESS 2932 A MOUNTAIN ROAD PASADENA, MARYLAND 21122				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-23-84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home 3204 Mountain Rd. 21122						25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE		

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



77	1907	1907
Operator	Operator	Operator
WAX	WAX	WAX

1907

1907

1907

1907 (date of)

1907 (date of)

1907

John. (date of)

1907-11-17

1907



1907-11-17

1907-11-17

1907-11-17

1907-11-17

1907-11-17

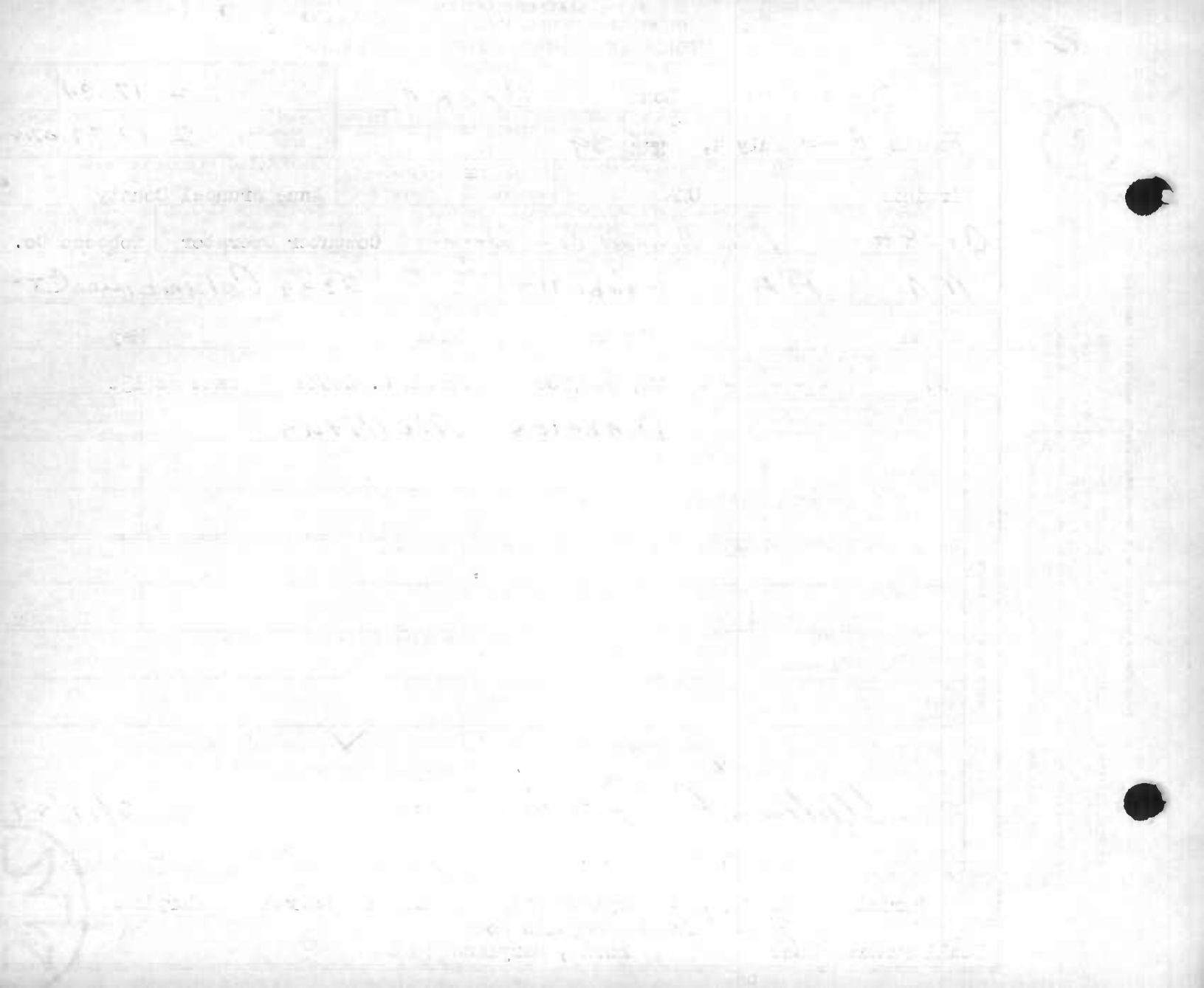
1907-11-17

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

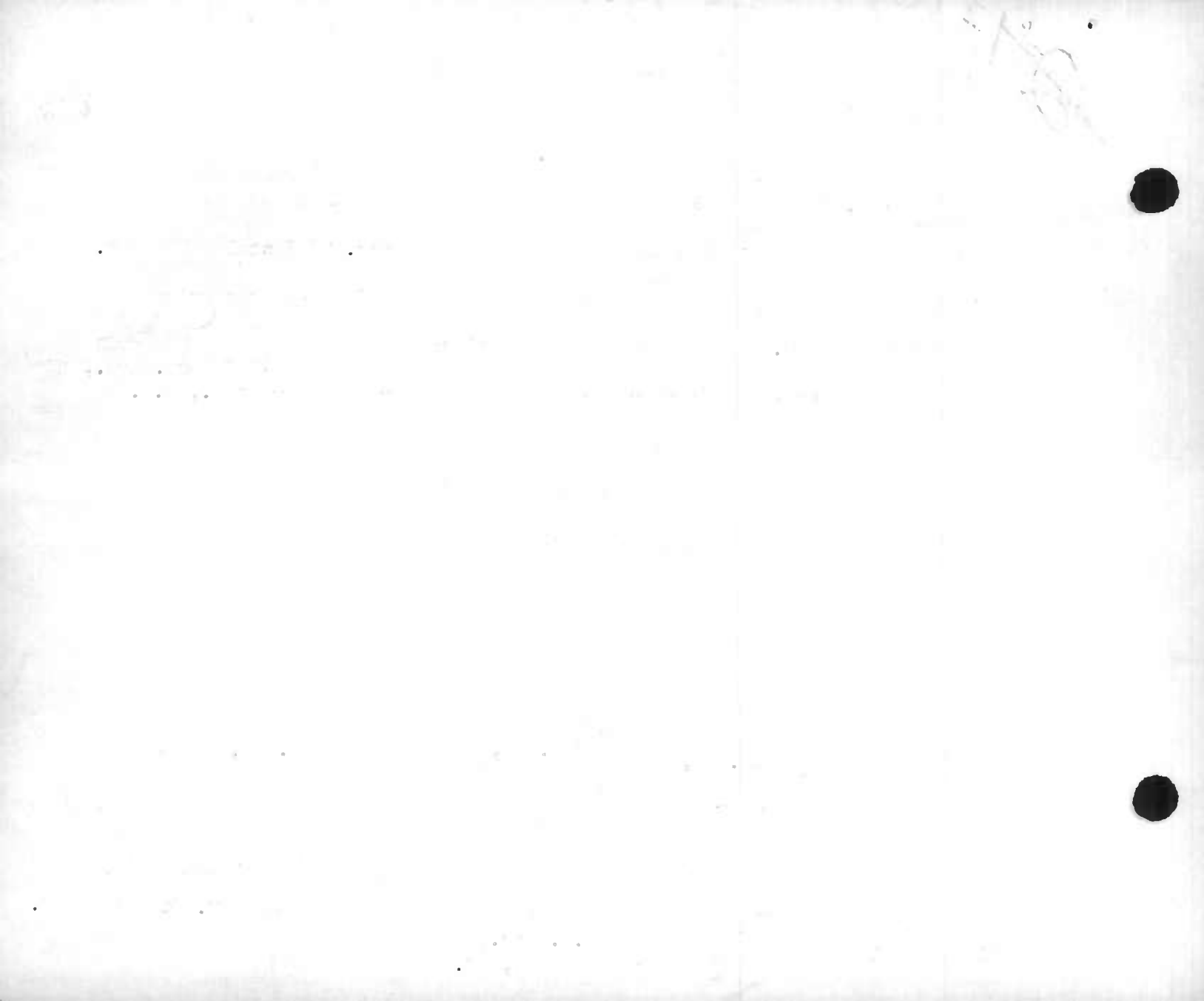
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Sandra Lou Cooke							2a. DATE KNOWN OF DEATH ESTIMATED 2 17 84		2b. HOUR 19 54		
3. SEX Female		4. RACE Cau		5. DATE OF BIRTH 1944 July 4, 1944		6. AGE (IN YEARS) 39 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 2 17 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County		
10. CITY OR TOWN OF DEATH Crofton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen. Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Operator			12b. KIND OF BUSINESS OR INDUSTRY Tobacco Co.		
13a. STATE Md.			13b. COUNTY AA		13c. CITY OR TOWN Gambrills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2334 Columbine Ct		
14. FATHER'S NAME FIRST MIDDLE LAST Eldon Moyers					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena May						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 227-60-7208			17. INFORMANT Kenneth L. Cooke			ADDRESS same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 2500 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE William P. Jones, M.D.				TITLE (SPECIFY) Deputy				DATE SIGNED 2/17/84			
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.				ADDRESS 695 America Ct Davidsonville 21035							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb 21 1984		23c. NAME OF CEMETERY OR CREMATORY Maryland National Mem Pk			23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Maryland			
24. FUNERAL DIRECTOR NAME Beall Funeral Home						25a. DATE REC'D. BY REGISTRAR FEB 21 1984		25b. REGISTRAR'S SIGNATURE [Signature]			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William F. Cornwell Sr.			2a. DATE OF DEATH MONTH DAY YEAR 2 12 84			2b. HOUR 4:40 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 11 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co. MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. US Postal		12b. KIND OF BUSINESS OR INDUSTRY US Govt.			
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 232 Edgewater Drive 21037			
14. FATHER'S NAME FIRST MIDDLE LAST Fred M. Cornwell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Davis			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW 1 578-10-5969		
17. INFORMANT 1343 Conn. Ave., NW			Jackie Eagan-daughter- Wash., D.C.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure 20</u> 4254 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery 20</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Atherosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) attended the deceased from <u>Jan. 30, 1984</u> to <u>Feb. 12, 1984</u> , that (I) (we) last saw the deceased alive on <u>Feb. 11, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <u>Don B. Lowe</u>			22c. ADDRESS <u>77 West St. Annapolis Md.</u>			22d. DATE SIGNED <u>12 Feb 84</u>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Don B. Lowe</u>			22f. ADDRESS <u>77 West St. Annapolis Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-15-1984		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION Brentwood Pr. Georges Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home			11800 N.H. Ave., Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR FEB 15 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randell</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.		EST	
1. FOR STATE REGISTRAR				2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FREDALINA C CROGHAN				MONTH DAY YEAR FEBRUARY 28, 1984		1117 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 11, 1923		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 60 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS / ZIP CODE			
13a. STATE Maryland		13b. COUNTY AA		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Payne				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evelyn Clowes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-12-5370		17. INFORMANT ADDRESS Manuel L. Croghan, Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest 3940 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Severe congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Severe Mitral Stenosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Azotemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASANT K. KHANDLWAL, M.D.				22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BOULEVARD GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 2 March 84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD	
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR MAR 1 - 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

EST

PRELIMINARY C PROGRESS FEBRUARY 28 1984 CITY WA

ANNIE ARUNDEL COUNTY

CLIN BRIGHT NORTH ARUNDEL HOSPITAL

7133 BALTIMORE-ANAPOLIS ROUTE
CLIN BRIGHT, MARYLAND 21061
RESIDENT / R. K. BARNETT, M.D.

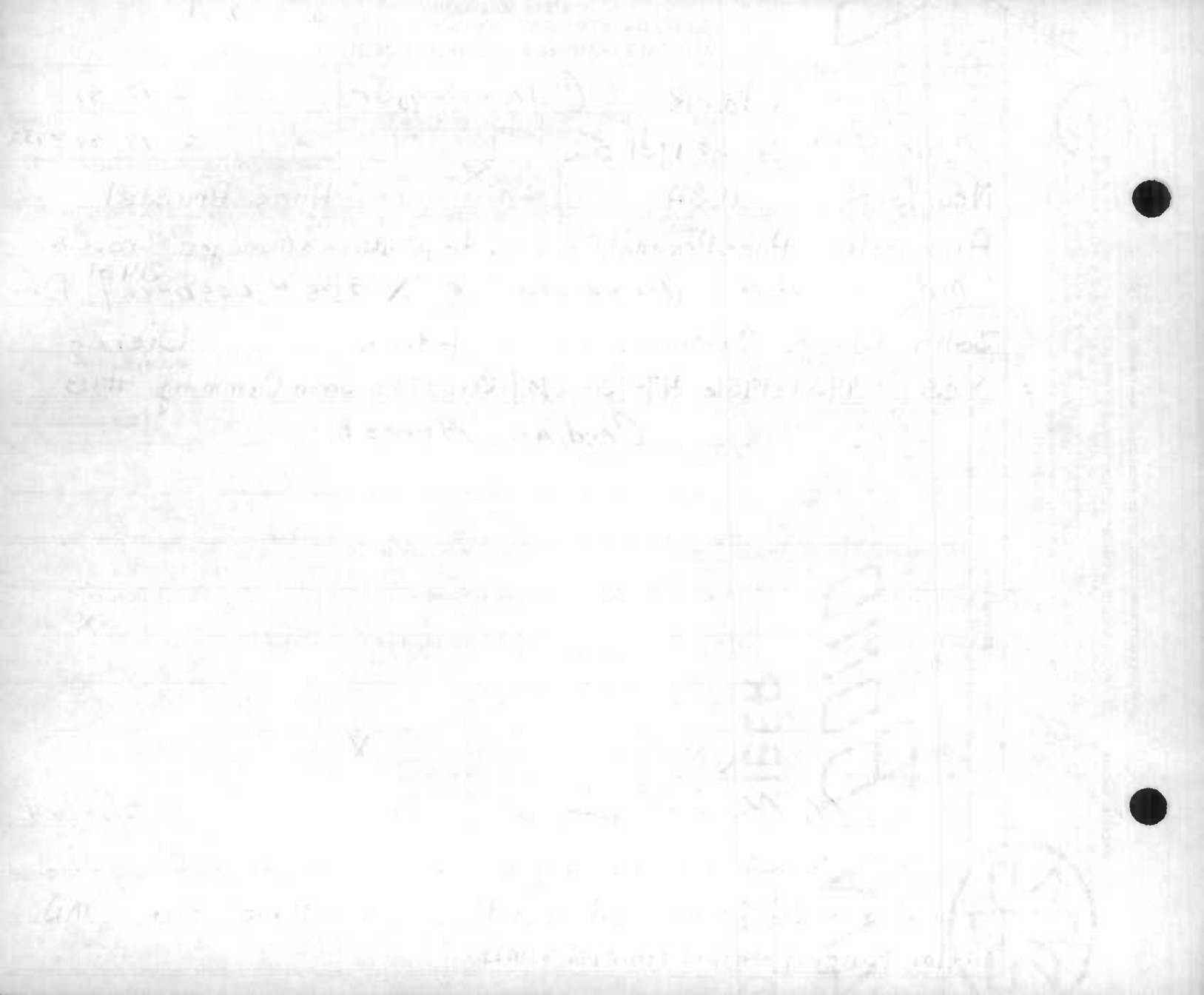
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (3))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) John Clark Cumming, Jr			2a. DATE KNOWN OF DEATH MONTH 2 DAY 17 YEAR 1984			2b. HOUR M 0452					
3. SEX Male	4. RACE Cau	5. DATE OF BIRTH MONTH 9 DAY 28 YEAR 1931	6. AGE (IN YEARS) LAST BIRTHDAY 52 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	7c. DATE PRONOUNCED DEAD MONTH 2 DAY 17 YEAR 1984		7d. HOUR M 0452			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Branch Manager		12b. KIND OF BUSINESS OR INDUSTRY Ins. Co.			
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21401 358 Kingsberry Dr.			
14. FATHER'S NAME FIRST John MIDDLE Clark LAST Cumming, Sr.				15. MOTHER'S MAIDEN NAME FIRST Adine MIDDLE Dieber LAST Dieber							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1954-1956 47-730-2907		17. INFORMANT Babette Joan Cumming				ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4275 Cardiac Arrest IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE William P. Jones, M.D.			TITLE (SPECIFY) DEPUTY			MEDICAL EXAMINER			DATE SIGNED 2/17/84		
EXAMINER'S NAME (TYPE OR PRINT) WILLIAM P. JONES, M.D.			ADDRESS 695 AMERICA CT DAVIDSONVILLE								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Feb. 20, 1984			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION CITY OR TOWN Suitland COUNTY P.G. STATE MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD						25a. DATE REG'D. BY REGISTRAR FEB 22 1984			25b. REGISTRAR'S SIGNATURE Jana Davidson-Fordell		

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) August M. Damps						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2 25 19 84					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 7 06		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
11a. CITY OR TOWN OF DEATH Annapolis				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired			
12b. KIND OF BUSINESS OR INDUSTRY City Gov't.				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel				MD.			
13a. STATE MD				13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INCLUDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15 Conduit Street	
14. FATHER'S NAME FIRST MIDDLE LAST August Damps						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily M. Collings					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WWII				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Gwendolyn Robinson - Arnold - MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac Arrest - Heart Attack DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sudden											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE James E. Wheeler				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) JAMES E WHEELER				ADDRESS 910 Primrose				DATE SIGNED 2-26-84			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial				23b. DATE Feb. 28, 1984				23c. NAME OF CEMETERY OR CREMATORY Hillcrest			
23d. LOCATION CITY OR TOWN Annapolis				COUNTY A.A.				STATE MD			
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD				ADDRESS				25a. DATE REC'D. BY REGISTRAR FEB 28 1984			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

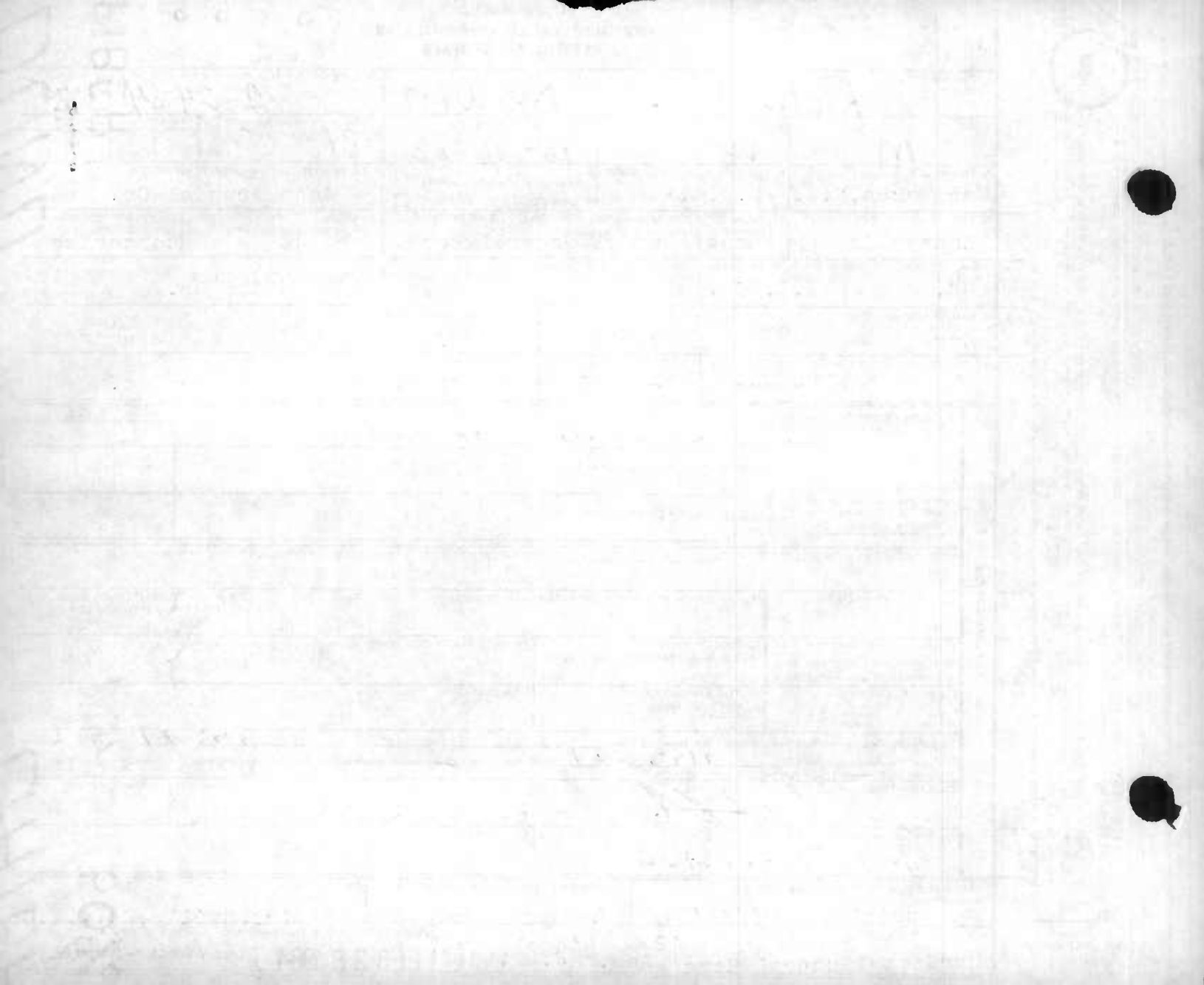
BP

DHMM - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH	
Richard W. De Witt		M		W		10-16-02	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Weehauken, N.J.		U.S.A.				Anne Arundel Co. MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Annapolis		Anne Arundel General Hosp.		artist		commerical	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		A.A. Co.		Mayo		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Guy		Effie Wagner		no		579-24-2286	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Martha H. DeWitt same as 13e.				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>probable lung cancer</u> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Jack Teicherbaum							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		2/27/84		Lakemont Cemetery		Davidsonville Md. A.A. Co.	
24. FUNERAL DIRECTOR NAME		12. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hardesty Funeral Home		Ann. Md. 21401		FEB 28 1984		Julia Davidson-Randall	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

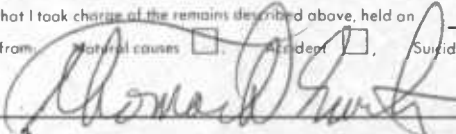
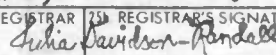
DHMH - 17
(VR A15 ME (5))
20M 4/82

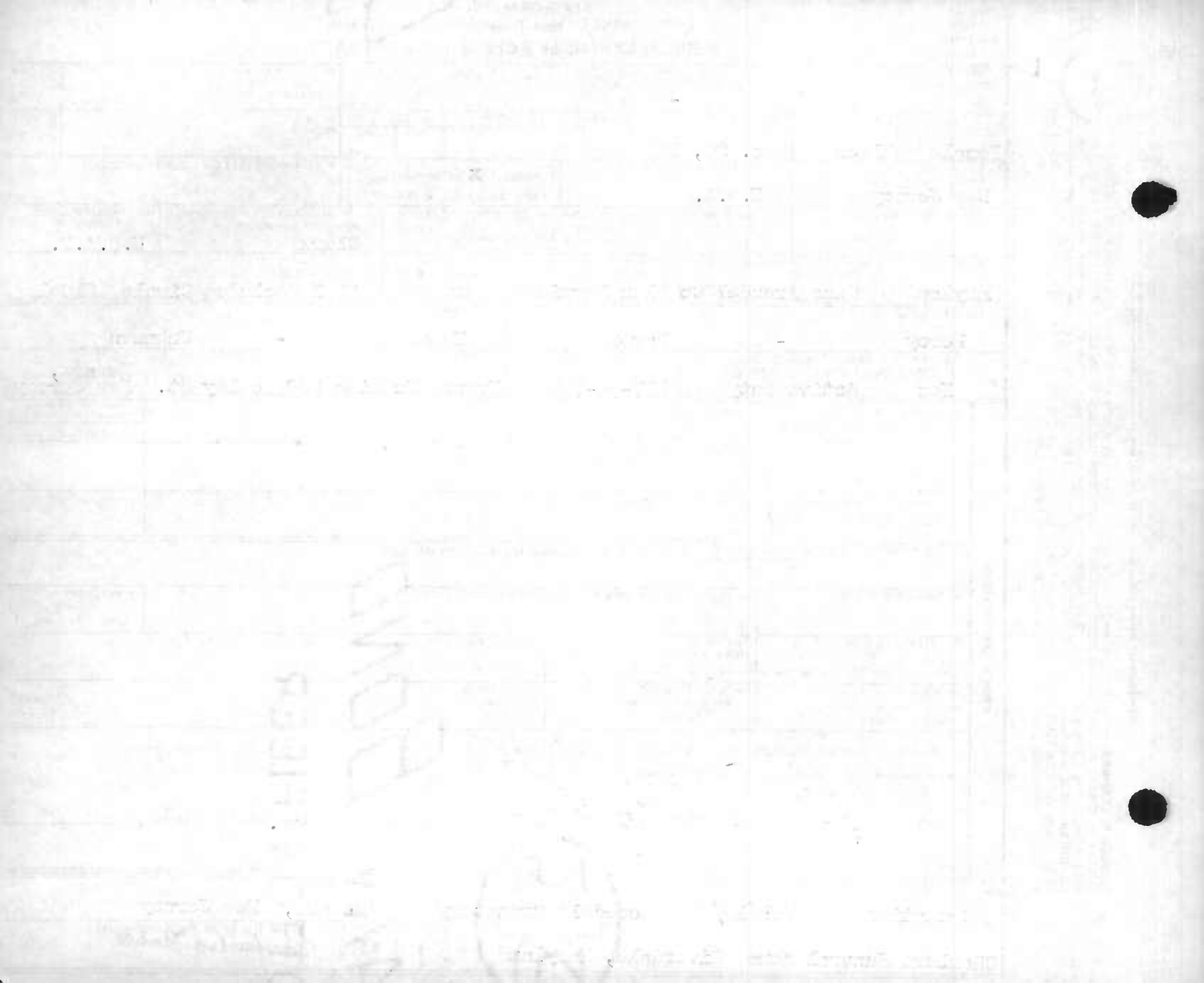
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

03167

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Renee			MIDDLE -			LAST Dorsey			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR				2b. HOUR	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1958		6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 7 19 84				2d. HOUR 1:50A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.					
10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 422 I Secluded Post Circle				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk				12b. KIND OF BUSINESS OR INDUSTRY U.S.A.F.					
13a. STATE Maryland				13b. COUNTY Anne Arundel Co		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 422 I Secluded Circle 21061							
14. FATHER'S NAME FIRST MIDDLE LAST Leroy - Baron						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yvonne - Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				(IF YES, GIVE WAR OR DATES) Active Duty		16b. SOCIAL SECURITY NO. 137-56-7249		17. INFORMANT Yvonne McClish				ADDRESS 289 Schley St. Newark, New Jersey					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Multiple stab wounds 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). DUE TO, OR AS A CONSEQUENCE OF (c).														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 00 2 6 19 84				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stabbed									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 422-I Secluded Post Circle, Glen Burnie, A.A. CO. MD.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				MEDICAL EXAMINER				DATE SIGNED 2/7/84					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn ST. Balto, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Feb/10/84		23c. NAME OF CEMETERY OR CREMATORY Rosedale Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Newark, New Jersey							
24. FUNERAL DIRECTOR NAME Chambers Funeral Home				ADDRESS Riverdale, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 14 1984				25. REGISTRAR'S SIGNATURE 					



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

03168

 1. FOR
STATE
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) Clementine			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 06, 1984			2b. HOUR 1:30 AM		
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1909		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		
13a. STATE MD			13b. COUNTY AA			13c. CITY OR TOWN Millersville		
14. FATHER'S NAME FIRST MIDDLE LAST James N. Austin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha J. (Unknown)			16. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD		
17a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			17b. SOCIAL SECURITY NO. XXXXXXX			17c. STREET ADDRESS / ZIP CODE 8242 Bernard Dr. S 21108		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			18b. SOCIAL SECURITY NO. 216/03/9646			18c. INFORMANT Donna Miller (granddaughter)		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) metastatic Colon Cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 day 18 months
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Arteriosclerotic Heart Disease	
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-5 19 84 , to 2-6 19 84 , that (I) (we) lost saw the deceased alive on 2-5 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Long S. Uchi, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. UCHI, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061					

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9 Feb. 84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn AA MD	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		25a. DATE REC'D. BY REGISTRAR FEB 7 1984		25b. REGISTRAR'S SIGNATURE John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03169

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Stella (Stanislava) Dzybinski</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>February 7, 1984</i>			2b. HOUR M				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 14 1896</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Poland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Poland</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Cape St. Claire</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1154 Little Magotthy View</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Md.</i>			13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Cape St. Claire</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Szymanski</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Antoinette Szczepanski</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT ADDRESS <i>Leo Jakowski 1154 Little Magotthy View</i>										

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral vascular accident</i> (c) <i>ASCVD</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> <i>72 hours</i>	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *None*

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 4 1984</i> to <i>Feb 7 1984</i> , that (I) (we) lost saw the deceased alive on <i>Feb 4 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2-11-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>	
24. FUNERAL DIRECTOR <i>John M. Weber & Sons Inc. 401 S. Chester St.</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 14 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

03170

 FOR
 1 - STATE
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William Wakeman Eckhart, Sr.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>February 6, 1984</i>		2b. HOUR <i>4:00 P.M.</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 13, 1905</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bay Manor Nursing Home, Inc.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Troubleshotter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>B.G. & E.</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <i>502 Wimmer Road, 21061</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>George Henry Eckhart</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Magdalene Emrine</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>Peacetime 212-05-5741</i>		17. INFORMANT ADDRESS <i>William W. Eckhart, Jr. Same as #13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Extensive Carcinoma of Lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>6-10-1983</i> to <i>2-6-1984</i> , that (I) (we) last saw the deceased alive on <i>2-1-1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>34</i>							
22b. SIGNATURE <i>Dr. Chackumkal V. Cyriac</i>				DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2-8-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Chackumkal V. Cyriac, M.D.</i>				22e. ADDRESS <i>14 Wellham Avenue, Glen Burnie, Md. 21061</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/10/1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Pk., Edridge, Howard, Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>McCully Funeral Homes</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 9 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Ganiel</i>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
JAMES EDWARD EISENHARDT			FEBRUARY 18, 1984			447 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE			7b. HOUR		
Male	White	Nov. 15, 1916	67 YRS.			447 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA		ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Salesman			Dairy Rt.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Anne Arundel			Pasadena		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
George Eisenhardt			Gertrude Carle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
No			215-09-3945			Elsie Eisenhardt, Same as # 13 E		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u> 2749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Joint.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2118</u> 19 <u>84</u> to <u>was seen in office</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2118</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. REGISTRAR'S SIGNATURE		
DR. DAJIT SAWHNEY			205 B & A BLVD. GLEN BURNIE, MARYLAND 21061			FEB 28 1984		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			Feb. 22, 1984			Glen Haven Mem. Park		
23d. LOCATION (CITY OR TOWN)			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE		
Glen Burnie A. No. Maryland			FEB 28 1984			Felia Davidson-Randall		
24. FUNERAL DIRECTOR (NAME) McCutty Funeral Home, 100 E. Pratt Ave. Baltimore, Md.								

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03172

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elsie Farr</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2-9-84</i>			2b. HOUR MIN. <i>5:25 P</i>				
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 4, 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i>		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Harwood, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co. MD.</i>				
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>adjustment clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>S. Kann's</i>		
13a. STATE <i>Md.</i>			13b. COUNTY <i>A.A. Co.</i>		13c. CITY OR TOWN <i>Edgewater</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3403 Hazelwood Rd. 21037</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Elmer Stallings</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maggie Farrell</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>				
16b. SOCIAL SECURITY NO. <i>579-10-7789</i>			17. INFORMANT ADDRESS <i>Melvin R. Farr Edgewater, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>1/2 coddles</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Hypertension</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>1-9 1984</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>1-9</i> , 19 <i>84</i> , to <i>2/9</i> , 19 <i>84</i> , that (he) (she) (it) was above, (I) (we) (did) (did not) view the body after death, <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE <i>Richard I. Hochman</i>						22c. DATE SIGNED <i>2/13/84</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Richard I. Hochman</i>		
22e. ADDRESS <i>16 Murray Ave. Annapolis, Md. 21401</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/13/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Lothian, Md. A.A. Co.</i>			
24. FUNERAL DIRECTOR NAME <i>Hardesty Funeral Home</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 15 1984</i>				
25b. REGISTRAR'S SIGNATURE <i>Lila Davidson-Randall</i>										

BP

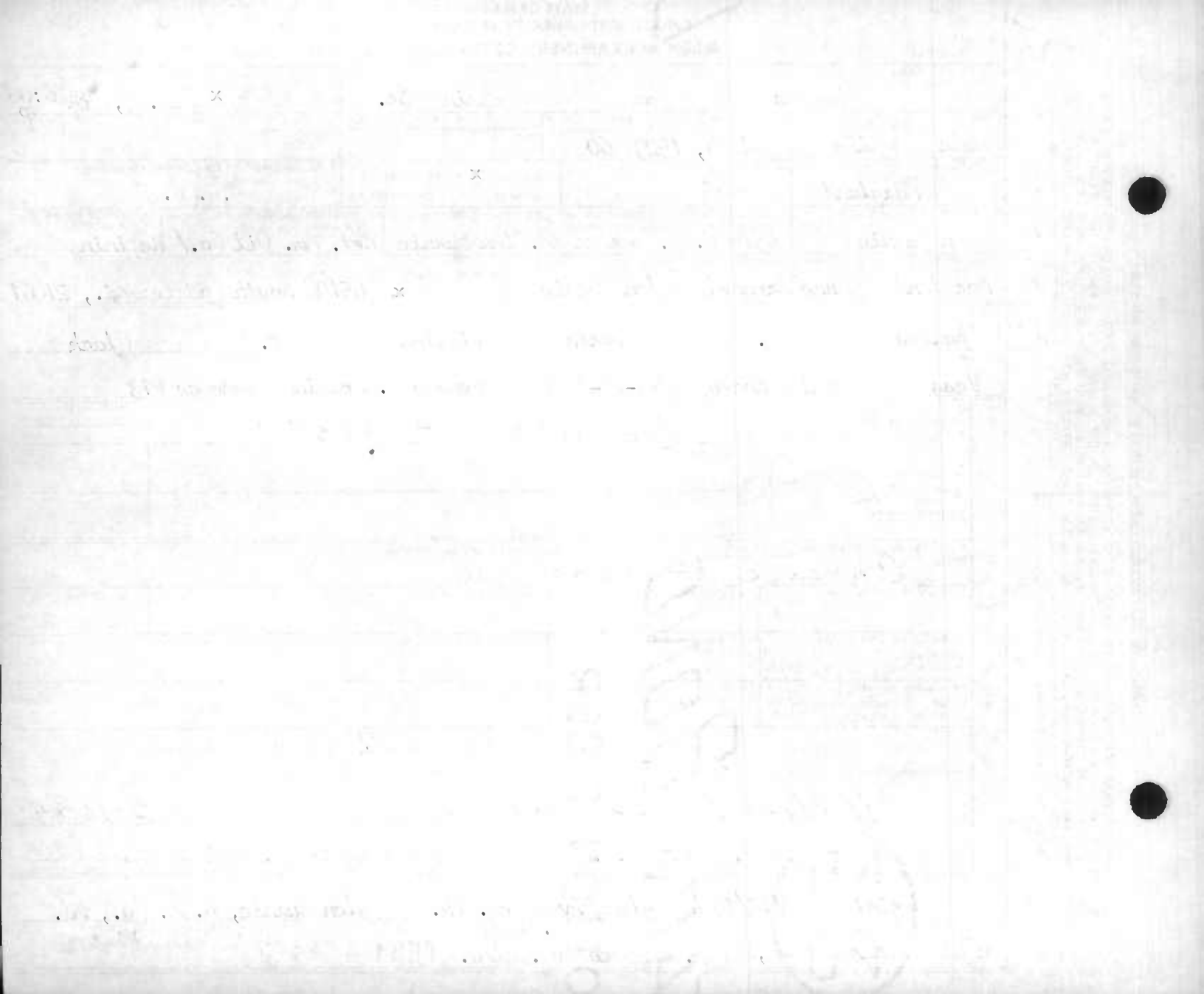


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Charles Earl Ferrin Sr.</i>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <i>Feb. 9, 1984</i>				2b. HOUR <i>6:00 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 4, 1923</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>60</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>19</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>A.A. Co.</i> MD.				
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>6510 H. S. Charter Rd. Glen Burnie</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Am. Oil Co./ Refining</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN <i>Glen Burnie</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>6510H South Charter Rd., 21061</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles E. Ferrin</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillian P. Clark</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. <i>215-18-3421</i>		17. INFORMANT ADDRESS <i>Lenora C. Ferrin Same as #13</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>4275 IMMEDIATE CAUSE (a) Cardiac Arrest.</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <i>Chronic Alcoholism</i> (c) <i>Chronic Alcoholism</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Chronic Alcoholism</i>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>William P. Jones</i>				TITLE (SPECIFY) <i>Deputy</i> M.D.				MEDICAL EXAMINER				DATE SIGNED <i>2-10-84</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>William P. Jones, M.D.</i>				ADDRESS <i>695 America ct. Davidsonville 21035</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/13/1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Pk.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Glen Burnie, A. A. Co., Md.</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>McCully Funeral Home, 237 E. Patapsco Ave. Balto.</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 14 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true, it shows any injury, or other traumatic event, the medical examiner must be notified of and

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03174	
1. FOR STATE REGISTRAR		1. DECEASED NAME [TYPE OR PRINT] BOYD J. FOUST				2a. DATE OF DEATH MONTH DAY YEAR 2-19-84				2b. HOUR 445^{PM}	
3. SEX M		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 01-18-09		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel, MD.					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 95 Tarragon Lane 21037			
14. FATHER'S NAME FIRST MIDDLE LAST Boyd Hower Foust				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha M. Jefferson				16. ADDRESS 95 Tarragon Lane			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-44-9805		17. INFORMANT Sylvia A. Spencer, Edgewater, Md.				18. TARRAGON LANE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio + respiratory arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Coronary artery disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe atherosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48-72 hrs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/19/84 to 2/19/84 , that (I) (we) last saw the deceased alive on 2/19/84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.											
22b. SIGNATURE David S. Krimins				22c. ADDRESS 25 Shaw Street, Annapolis, Maryland				22d. DATE SIGNED 2/19/84			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) David S. Krimins, MD		22f. ADDRESS 25 Shaw Street, Annapolis, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-22-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery Annapolis, A.A., Md.				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Beall-Evans Funeral Home, Annapolis, Md.		24b. DATE REC'D. BY REGISTRAR FEB 21 1984		24c. REGISTRAR'S SIGNATURE Sylvia Davidson-Randall							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FREDERICKSON RODERIC MUIR			2a. DATE OF DEATH MONTH DAY YEAR 2 26 84		2b. HOUR 5 42 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug 22, 1932	6. AGE (IN YEARS LAST BIRTHDAY) 51		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.			
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) Partner		12b. KIND OF BUSINESS OR INDUSTRY Consulting	
13a. STATE MD		13b. COUNTY A.A.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 111 Spa View Avenue 21401	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Frederickson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gayle Daley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 671-32-0901		17. INFORMANT ADDRESS Gloria Frederickson - Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Ventricular tachycardia. DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from January 19 84 to Feb 26 19 84 , that (I) (we) lost saw the deceased alive on Jan 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE George P. Samaras		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/27/84
22b. PHYSICIAN'S NAME (TYPE OR PRINT) George P. Samaras		22c. ADDRESS 205 Ridgely Ave Annapolis MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb 28 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY Switland P.G. MD
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis MD				25a. DATE REC'D. BY REGISTRAR FEB 28 1984		
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANK Theodore Gale			2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR ESTIMATED <input type="checkbox"/> Feb. 8 1984			2b. HOUR 1413		
3. SEX M	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 24 90	6. AGE (IN YEARS) LAST BIRTHDAY 94 YRS.	IF UNDER 1 YR. MONTHS DAYS 1 14	IF UNDER 24 HRS. HOURS MIN. 14 13	2c. DATE PRONOUNCED DEAD Feb. 8 1984		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dispatcher (ret)		12b. KIND OF BUSINESS OR INDUSTRY Railroad
13a. STATE Md.			13b. COUNTY A.A.	13c. CITY OR TOWN Odenton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 955 Patuxent Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST Walter Gale				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Maslin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES) None		16b. SOCIAL SECURITY NO. 717-07-8929		17. INFORMANT ADDRESS Margaret G. Mills (daughter) same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE William P. Jones, MD			TITLE (SPECIFY) Deputy			DATE SIGNED 2-8-84.		
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.			ADDRESS 695 America Ct. Davidsonville 21035					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Prk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, Maryland	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home-Glen Burnie, Md.					25a. DATE REC'D. BY REGISTRAR FEB 10 1984		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VICTOR M. GALVIN			2a. DATE OF DEATH MONTH DAY YEAR 2 6 84		2b. HOUR MIN. 3⁰⁰ A
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12 3 1928	6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHICAGO, IL.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.		
10. CITY OR TOWN OF DEATH BROOKLYN	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 102 10th AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONTRACTOR		12b. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.	13b. COUNTY A.A.	13c. CITY OR TOWN BROOKLYN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 102 10th St. (21225)	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS W. GALVIN SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSEZELLA CALDWELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT ADDRESS Apt. 11 (21061) THOMAS GALVIN JR. 8077 Budding Branch Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) widely metastatic adenocarcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8/83					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from September 19 83 to February 19 84 , that (I) (we) last saw the deceased alive on January 23 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Aron W. Berkman		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/6/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aron W Berkman		22e. ADDRESS 3001 S. Hanover St Baltimore, Md, 21230			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/10/84	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Ltrobe Westmoreland Pa.		
24. FUNERAL DIRECTOR NAME George J. Gonce F.H. 4001 Ritchie Hwy.		25a. DATE REC'D. BY REGISTRAR FEB 8 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) HELEN Thayer GEISSMAN			2a. DATE OF DEATH MONTH DAY YEAR 2 3 84			2b. HOUR 10 P M					
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7 5 15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD					
10. CITY OR TOWN OF DEATH EDGEWATER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PLEASANT LIVING CONVAL. CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RECEPTIONIST		12b. KIND OF BUSINESS OR INDUSTRY OFFICE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD				13c. CITY OR TOWN ANNE ARUNDEL ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2 MARYLAND AVE 21401			
14. FATHER'S NAME FIRST MIDDLE LAST G. BLAINE GEISSMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL F. THAYER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 216 222536		17. INFORMANT ADDRESS 400 Elmwood Road Roberta Marsh - Baltimore MD 21206							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA 1749 DUE TO, OR AS A CONSEQUENCE OF OF BREAST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.											
22b. SIGNATURE John B. Lowe						DEGREE		22c. DATE SIGNED 2/3/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Lowe						22e. ADDRESS 77 West St. Annapolis, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AR MD				
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD						ADDRESS		25. DATE REC'D. REGISTRAR'S SIGNATURE FEB 8 1984 John J. Carter			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03179			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2 28 84			
1. DECEASED NAME FIRST MIDDLE LAST murriel G. Giles				2b. HOUR 12 ²⁵ P.M.			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 3 19 22		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Friendship	
14. FATHER'S NAME FIRST MIDDLE LAST Earle Giles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Rawlings			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 218-12-9103		17. INFORMANT ADDRESS Mary T. Giles 313 Sansbury Rd., Friendship	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cardiac arrest							
5309 DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) mediastinal mass, diagnosis unknown							
19a. DATE OF OPERATION 2-24-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED esophagoscopy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-28 19 84 to 2-28 19 84, that (I) (we) last saw the deceased alive on 2-28 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Karl R. Holschuh				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KARL HOLSCUH				22e. ADDRESS 16 Murray Ave. Annapolis			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 3-1984		23c. NAME OF CEMETERY OR CREMATORY Carters Chr. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Friendship A.A. Md.	
24. FUNERAL DIRECTOR NAME Spencer E. Sewell				ADDRESS Box 31, Prince Frederick, Md		25. DATE RECEIVED BY REGISTRAR REGISTRAR'S SIGNATURE MAR 05 1984 Julia Davidson-Randall	

THE UNIVERSITY OF CHICAGO
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1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Margaret Angelion Gillock				February 25, 1984				7 30 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
Female		White		April 24, 1909		74 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		2b. HOUR	
Virginia		USA				Anne Arundel		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		2b. HOUR	
Hanover		902 Hillcrest Road		housewife		home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md		AA		Hanover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		902 Hillcrest Road 21076	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Arch Leroy Bright		Leola Lone		no		215 30 6743		Wilma J. Cecil same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100		Cardiac Arrest		Myocardial infarction		1 month			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF		years			
		(c)		Hypertension					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4 19 82 to 2 25 19 84, that (I) (we) lost saw the deceased alive on 2-21 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
J. L. E. DE, MD						2/20/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
J. L. E. DE, MD		16802 Hickory Ridge Rd., Col. Md 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Feb. 29, 1984		Meadowridge Mem. Park		Dorsey, Md			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Donaldson Funeral Home, Laurel, Md				MAR 07 1984		John Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours of death. Pages 3 and 4 should be filed within 72 hours of burial. Pages 1 and 2 should be removed from the certificate and placed in the body of the deceased. Pages 3 and 4 should be placed in the body of the deceased. Pages 1 and 2 should be placed in the body of the deceased. Pages 3 and 4 should be placed in the body of the deceased.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

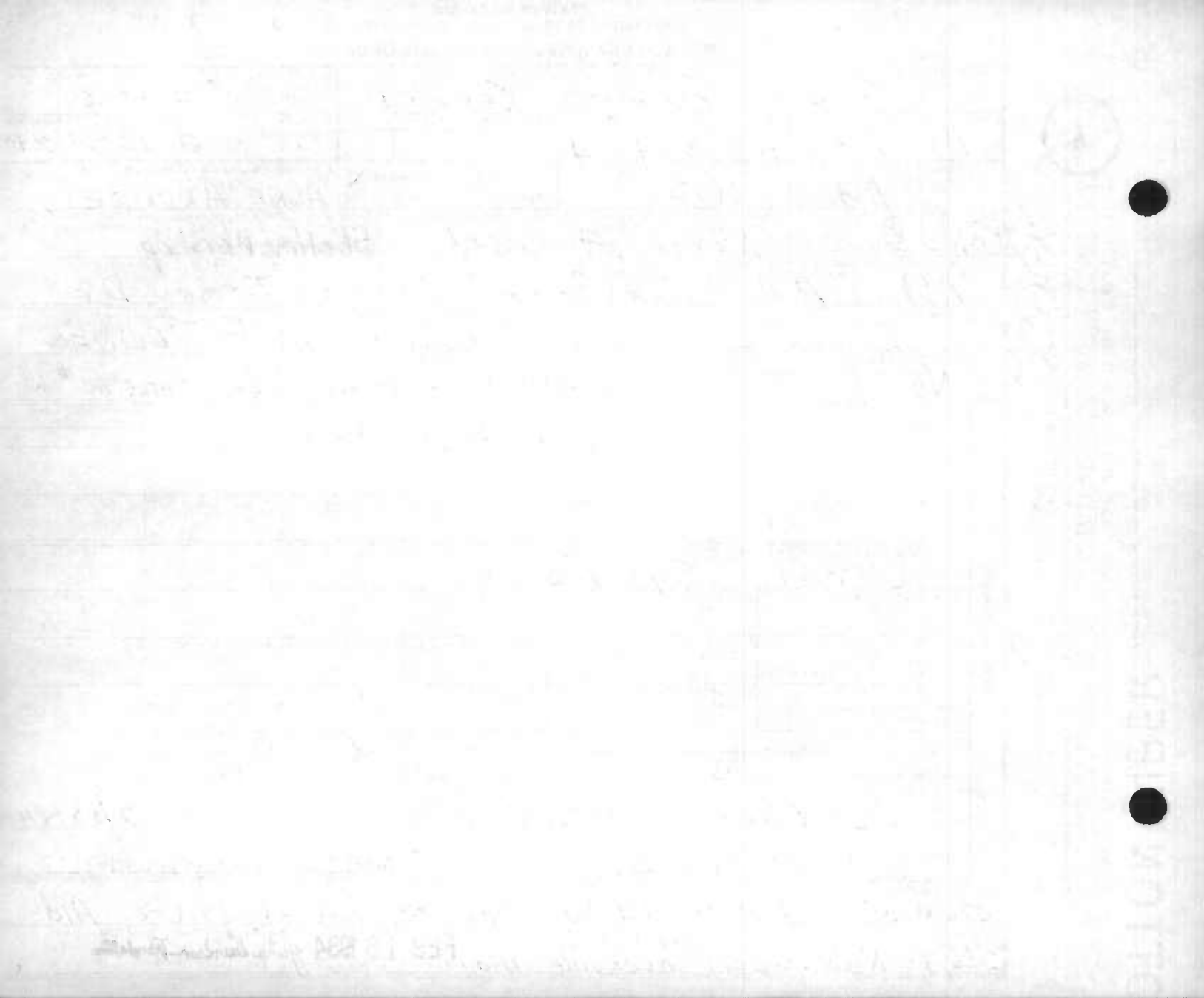
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GARY Eugene Green			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> 2 DAY 13 YEAR 1984			2b. HOUR M 06		
3. SEX M	4. RACE Neg	5. DATE OF BIRTH MONTH 08 DAY 13 YEAR 59	6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH 2 DAY 13 YEAR 1984	7d. HOUR M 06	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel			12a. USUAL OCCUPATION (TYPE OF WORK) Shelter Workshop		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY AA	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1421 Tieman Dr.		
14. FATHER'S NAME FIRST ELMER E. MIDDLE GREEN LAST GREEN			15. MOTHER'S MAIDEN NAME FIRST GWENDOLYN MIDDLE F. LAST TOWNES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-82-2064		17. INFORMANT Elmer Green (father) ADDRESS SAME AS #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 3314 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Viral Syndrome								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE William P. Jones			TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER			DATE SIGNED 2/13/84		
EXAMINER'S NAME (TYPE OR PRINT) WILLIAM P. JONES, M.D.			ADDRESS 695 AMERICA CT. DAVIDSONVILLE					
23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL		23b. DATE 2-18-84		23c. NAME OF CEMETERY OR CREMATORY Md. Nat'l. Mem. Pk.		23d. LOCATION CITY OR TOWN P.R. Geo. COUNTY Md. STATE		
24. FUNERAL DIRECTOR NAME George R. Snowden ADDRESS 246 N. Wash. ST. Rockville, Md.			25. DATE REC'D. BY REGISTRAR FEB 16 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

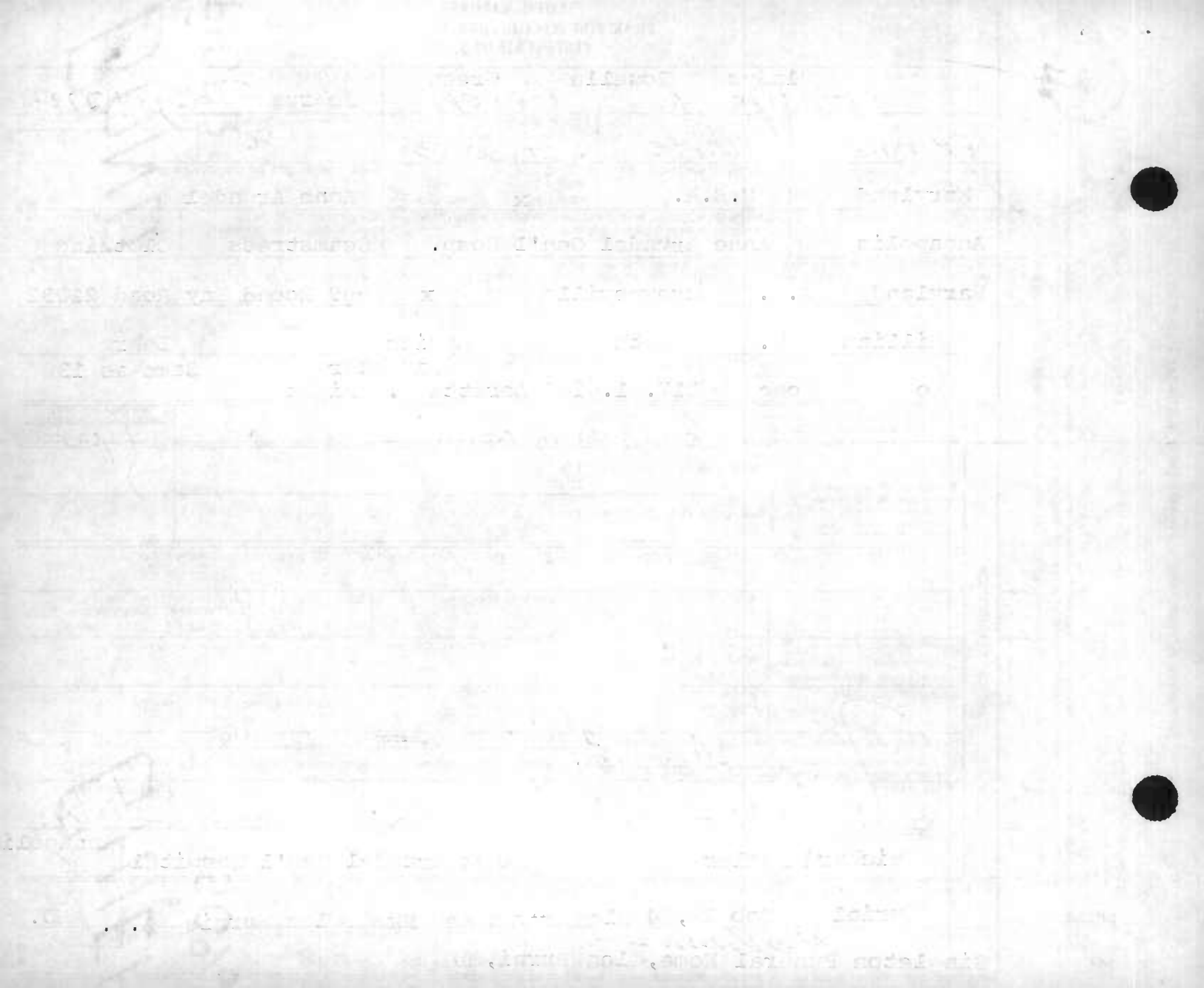
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03182

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Gladys</u> MIDDLE <u>Rosella</u> LAST <u>Green</u> <u>Gladys R. Green</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>February</u> <u>25</u> <u>84</u>		2b. HOUR <u>2:28 P.M.</u>
3. SEX <u>Female</u>	4. RACE <u>White</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>July</u> <u>30</u> <u>03</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>80</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel</u> MD.		
10. CITY OR TOWN OF DEATH <u>Annapolis</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel Gen'l Hosp.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Seamstress</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>A.A.</u>	13c. CITY OR TOWN <u>Crownsville</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>989 Round Bay Road 21032</u>
14. FATHER'S NAME FIRST MIDDLE LAST <u>William H. Roth</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Louise Lehr</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u> <u>None</u>		16b. SOCIAL SECURITY NO. <u>217.01.0186</u>	17. INFORMANT <u>Daughter</u> ADDRESS <u>Loretta H. Knight</u> Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Endometrial carcinoma</u> <u>1820</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/10/84</u> , 19 <u>84</u> , to <u>2/25/84</u> , 19 <u>84</u> , that (I) (we) lost the deceased alive on <u>2/25</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard Peeler</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>2/25/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard Peeler</u>		22e. ADDRESS <u>Anne Arundel Gen'l Hospital</u> <u>Annapolis Md</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>Feb 28, 84</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem Pk</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Glen Burnie A.A. MD.</u>	25a. DATE REC'D. BY REGISTRAR <u>FEB 28 1984</u>	
24. FUNERAL DIRECTOR NAME <u>Singleton Funeral Home</u> ADDRESS <u>Glen Burnie, MD</u>		25b. REGISTRAR'S SIGNATURE <u>ne Harrison</u>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ROSALIE MARGARET GREENE										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> FEB 18 1984	
2. SEX FEMALE		3. RACE BLACK		5. DATE OF BIRTH NOV 10 1890		6. AGE (IN YEARS) 93 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. HOUR PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. MD		2c. DATE PRONOUNCED DEAD FEB 18 1984		2d. HOUR PM	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 430 BOSTON HGT CIRCLE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 430 BOSTON HGT CIRCLE		2e. HOUR PM	
14. FATHER'S NAME (FIRST MIDDLE LAST) ALFRED JOHNSON				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) ELIZA UNKNOWN				16. SOCIAL SECURITY NO. 212-54 9954		17. INFORMANT MISS ELIZABETH GREENE	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				18b. SOCIAL SECURITY NO. 212-54 9954				18c. ADDRESS ANNAPOLIS, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) 4275 DUE TO, OR AS A CONSEQUENCE OF (c) 4275 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Coronary											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE William P. Jones, M.D.				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 18 Feb 84			
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.				ADDRESS 695 America Ct Davidsonville 21035							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE FEB 24 1984		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. MD			
24. FUNERAL DIRECTOR NAME C.E. HICKS				ADDRESS 1922 Forest Drive		25a. DATE REC'D. BY REGISTRAR FEB 29 1984		25b. REGISTRAR'S SIGNATURE John A. Hensell			

RECEIVED BY THE DIRECTOR OF THE
BUREAU OF THE ARMY MEDICAL DEPARTMENT
WASHINGTON, D. C.

TO THE DIRECTOR OF THE
BUREAU OF THE ARMY MEDICAL DEPARTMENT
WASHINGTON, D. C.

FROM THE
BUREAU OF THE ARMY MEDICAL DEPARTMENT
WASHINGTON, D. C.

RECEIVED BY THE DIRECTOR OF THE
BUREAU OF THE ARMY MEDICAL DEPARTMENT
WASHINGTON, D. C.

RECEIVED BY THE DIRECTOR OF THE
BUREAU OF THE ARMY MEDICAL DEPARTMENT
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03184			
1. FOR NURSING REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) RUTH				2a. DATE OF DEATH MONTH 2 DAY 10 YEAR 84			
3. SEX F		4. RACE N		5. DATE OF BIRTH MONTH 5 DAY 6 YEAR 04		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BAY MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN CHURCHTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST ALEXANDER MIDDLE LAST HOLLAND		15. MOTHER'S MAIDEN NAME FIRST CORA MIDDLE LAST BLAKE		13e. STREET ADDRESS 5670 Shady Side Road 20733			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RODNEY GROSS 1141 Deep Cove Rd. Churchton, Md. 20733			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 19 81 , to 2. 10. 19 84 , that (I) (we) last saw the deceased alive on 2. 8. 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William Reese MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2. 10. 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHACKUMKAL. V. CYRIAC				22e. ADDRESS SUIT 101 14 WELHAM AVE, GLENBURNIE MD 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-14-84		23c. NAME OF CEMETERY OR CREMATORY GROSS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CHURCHTON A.A. MARYLAND	
24. FUNERAL DIRECTOR Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.				25a. DATE REC'D. BY REGISTRAR FEB 14 1984 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARJORIE A HAINES			2a. DATE OF DEATH MONTH DAY YEAR 2/13/84		2b. HOUR 1:35 AM
3. SEX FEMALE	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR FEB 4, 1942		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN'L Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY	12b. KIND OF BUSINESS OR INDUSTRY F.B.I.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Prince Geo.	13c. CITY OR TOWN Bowie	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2807 Spiral Lane 20715	
14. FATHER'S NAME FIRST MIDDLE LAST NORMAN ADAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARJORIE BUTLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-40-6564	17. INFORMANT ADDRESS TRACY L. HAINES (Husband) same as 13e			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Metastatic Melanoma

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

6 months

1729

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from 2/5 1984 to 2/13 1984, that (I) (we) last saw the deceased alive on 2/11 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If over) (did not) (saw the body after death).			
22b. SIGNATURE E. W. COLE JR	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/13/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. W. COLE		22e. ADDRESS 51 FRANKLIN ST ANNAP MD.	

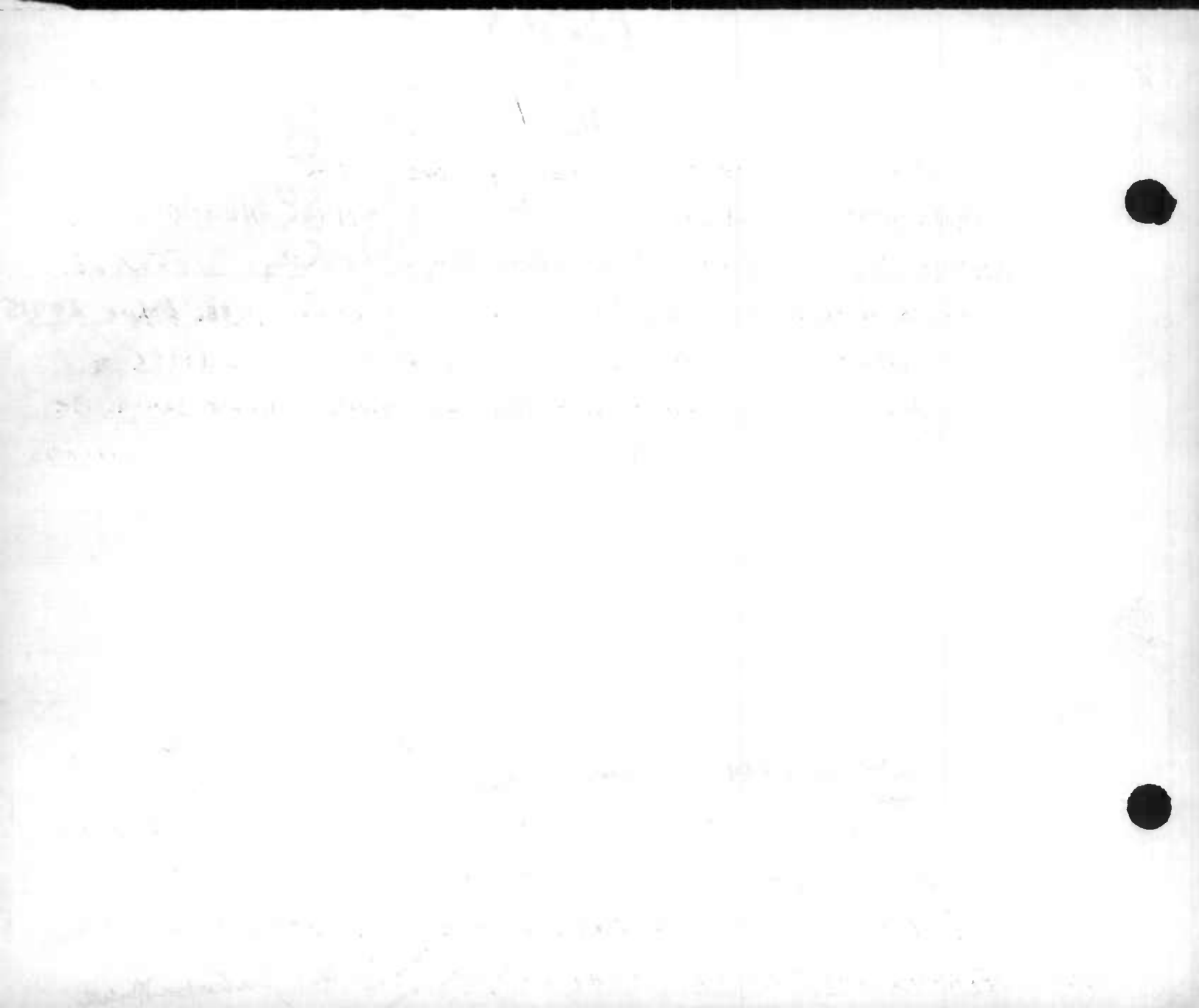
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE FEB 17, 1984	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD P. G. MD.
24. FUNERAL DIRECTOR NAME FRANCIS GASCH'S SONS F.H.		25. DATE REC'D. BY REGISTRAR FEB 16 1984	
ADDRESS HYATISVILLE, MD.		25b. REGISTRAR'S SIGNATURE John Davidson	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD L. HAMPTON			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 10, 1984		2b. HOUR 7:30 AM								
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 5 34		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH GLEN BURNIE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2827 W. Garrison Ave. 21215				
14. FATHER'S NAME FIRST MIDDLE LAST Herbert Norris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Missie Smith										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 227-42-2112			17. INFORMANT ADDRESS Shirley Hampton 2827 W. Garrison Ave.							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Pulmonary Hemorrhage
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) Recurrent lung cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) Pneumonia lung cancer

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 hr
1 yr.
2 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive pulmonary disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> 19 <u>84</u> to <u>2/10</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S. HSU, M.D.				22e. ADDRESS 7845 OAKWOOD ROAD, #104 GLEN BURNIE, MARYLAND 21061			

23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2/17/84		23c. NAME OF CEMETERY OR CREMATORY Riverview Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Richmond, Va.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm C March F/H Inc, 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR FEB 14 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

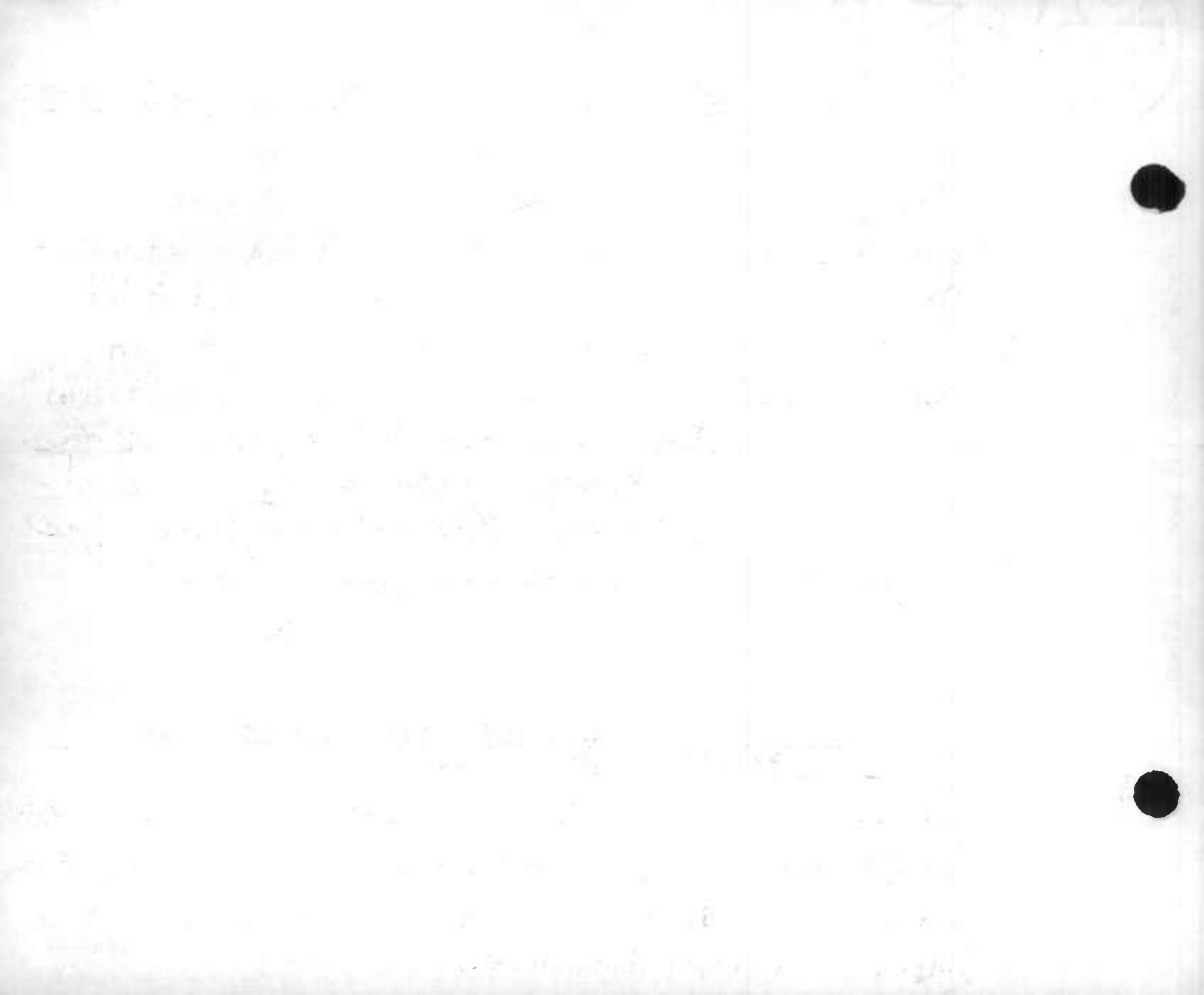
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD E. Harbold					2a. DATE OF DEATH MONTH DAY YEAR Feb. 23, 1984	
3. SEX MALE		4. RACE CAUCASIAN		2b. HOUR 2:55 PM		
5. DATE OF BIRTH MONTH DAY YEAR 1-10-13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7b. HOUR 2:55 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. State		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY State Gov't.				
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		
14. FATHER'S NAME FIRST MIDDLE LAST Robert P. Harbold, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosemary Brown		13d. STREET ADDRESS / ZIP CODE 1503D West Street 21401		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR NAVY) WWII 206098468		17. INFORMANT ADDRESS John C. Harbold-Annapolis, MD 21401		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas Pneumonia</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Lung Disease - yrs</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 6 mo -						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>S/P resection of Cancer of the Rectum</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>Jan. 29, 1984</u> to <u>Feb. 23, 1984</u> , that (I) (we) last saw the deceased alive on <u>Feb. 23, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
23a. SIGNATURE Gary M. Richardson, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Feb. 23, 1984		
23b. PHYSICIAN'S NAME (TYPE OR PRINT) Gary M. Richardson, M.D.		22e. ADDRESS 104 Forbes Street Annapolis, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb 28, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		
23d. LOCATION CITY OR TOWN Suitland		COUNTY PG.		STATE MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis MD		ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 28 1984		
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 through 7 are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										EST	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) CRESENTHIA TERESA HARKUM						2a. DATE OF DEATH MONTH FEBRUARY DAY 13 YEAR 1984			2b. HOUR 1131 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 6 DAY 21 YEAR 13		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waitress		12b. KIND OF BUSINESS OR INDUSTRY restaurant			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 223 Carvel Rd. 21122			
14. FATHER'S NAME FIRST Paul MIDDLE M. LAST Yesker						15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE T. LAST Neubeck					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214 14 7056		17. INFORMANT ADDRESS Arthur E. Harkum (same as 13E)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest - 4100 DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) NSAD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1970 , 19____, to 2/13/84 , 19____, that (I) (we) lost the deceased alive on Feb 3 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE Jorge B. Ramirez				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/14/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JORGE B. RAMIREZ, M. D.				22e. ADDRESS 7845 OAKWOOD ROAD GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/17/84		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery				23d. LOCATION CITY OR TOWN Brooklyn COUNTY A.A. STATE Md.			
24. FUNERAL DIRECTOR NAME George J. Gonce				4001 Ritchie Hwy. ADDRESS Baltimore Md. 21225				25. DATE REC'D BY REGISTRAR FEB 15 1984 REGISTRAR'S SIGNATURE John Davidson-Randall			

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

121

CHINESE/THAI THIRDA HOURS
FEBRUARY 12, 1982 1:21 PM



TO: SAC, NEW YORK (100-100000) FROM: SAC, NEW YORK (100-100000)

RE: [Illegible]

DATE: 2/12/82 BY: [Illegible]

100-100000-1000

100-100000-1000

100-100000-1000

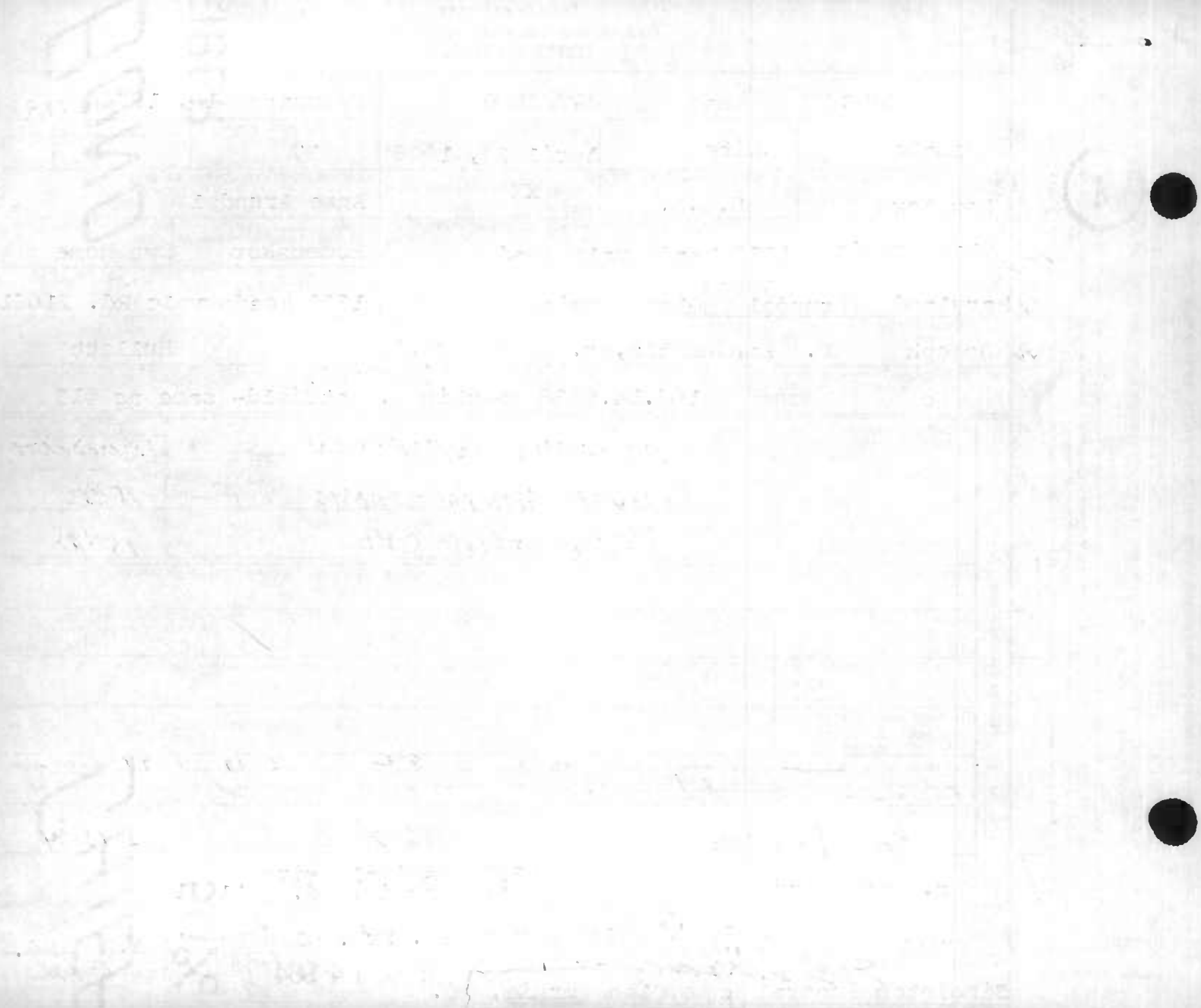


100-100000-1000

100-100000-1000

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100-100000-1000



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

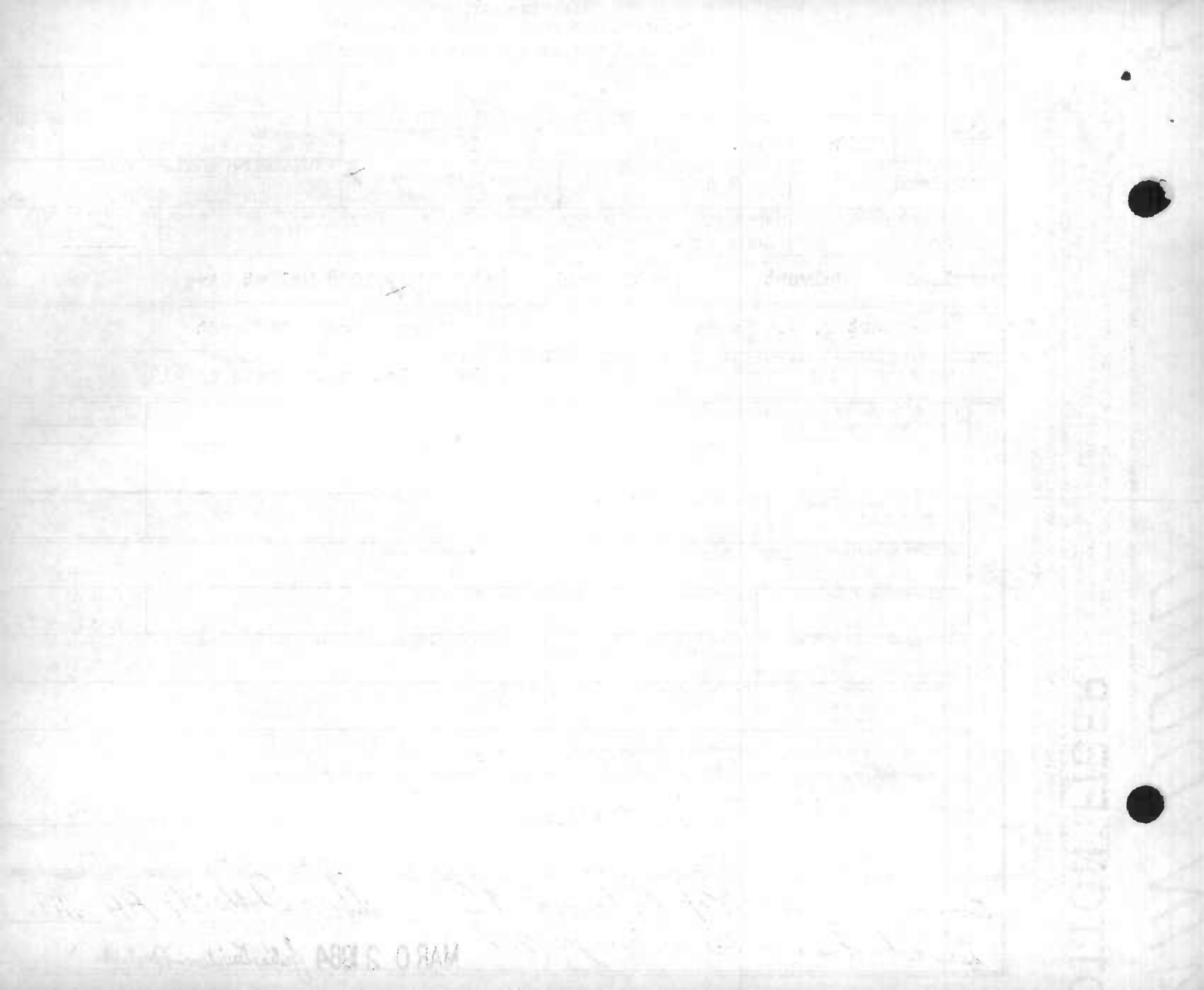
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Thomas			MIDDLE P.			LAST F. Hayes			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2/26/84			2b. HOUR 7:14 A.M.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 7, 1984		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS 012 YRS. 1 19		IF UNDER 1 YR. MONTHS DAYS 19		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD 2/26/84			7d. HOUR A.M.				
8. BIRTHPLACE (STATE OR)				7b. CITIZEN OF WHAT COUNTRY?				MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.							
10. CITY OR TOWN OF DEATH Annapolis				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland Palver North Beach												13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 1052 Walnut Ave 20714					
14. FATHER'S NAME FIRST MIDDLE LAST Herbert T. F. Hayes												15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sharon Lou Gebhardt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. NONE				17. INFORMANT ADDRESS Sharon Lou Hayes same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Margarete Meynell</i>				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 2/27/84							
EXAMINER'S NAME (TYPE OR PRINT)				Margarita A. Korell, M.D. ADDRESS 111 Penn St. Balto. Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (TYPE)				23b. DATE 2/29/84				23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery				23d. LOCATION (CITY OR TOWN) COUNTY STATE Chesapeake AA Md							
24. FUNERAL DIRECTOR NAME <i>Funeral Home Corp Md</i>				25a. DATE REC'D. BY REGISTRAR MAR 0 2 1984				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											



RECEIVED
JAN 19 1964

MAR 2 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03191

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) KATHERINE Louise HILL			2a. DATE OF DEATH MONTH 2 DAY 16 YEAR 84 1115P M		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 7 DAY 24 YEAR 08	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Secretary	12b. KIND OF BUSINESS OR INDUSTRY Civil Service		
13a. STATE MD		13b. COUNTY A.A	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 105 Americana Drive 21403
14. FATHER'S NAME FIRST Owen MIDDLE LAST Hill		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Elizabeth LAST Sommers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-44-9695		17. INFORMANT ADDRESS 86 Gloucester St Eleanor O'Neill - Annapolis, MD 21401	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4960 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULM. DS DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 2/16/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 2/16/84 to 2/16/84 , that (1) (we) lost saw the deceased alive on 2/16/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. David Krimsins		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. David Krimsins, M.D.		22e. ADDRESS 25 Shaw Street, Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 21, 1984		23c. NAME OF CEMETERY OR CREMATORY US Naval Academy	
23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD		24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel - Annapolis, MD			
25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE F. A. Davidson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03192		EST		
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN M HOCK					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 1, 1984			2b. HOUR 710 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 12 02		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.								
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Advertising		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY A.A.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 408 Forrest View Road 21090						
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Hock					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Maria Rethly									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 326-03-1656		17. INFORMANT ADDRESS August Lundquist Same as 13e										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 4340 DUE TO, OR AS A CONSEQUENCE OF (b) Rt. Middle Cerebral Artery Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestion Heart Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1-19-84 21184										
22a. I certify that (I) (this hospital) attended the deceased from 1-19-84, 19, to 2-1-84, 19, that (I) (we) last saw the deceased alive on 2-1-84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 2/2/84				
22b. SIGNATURE Alejandro Montoya, M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALEJANDRO MONTOYA, M. D.				22e. ADDRESS 707 OLD ANNAPOLIS ROAD GLEN BURNIE, MARYLAND 21061										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/3/84		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md								
24. FUNERAL DIRECTOR NAME George J. Gonce				4001 Ritchie Hgwy Balto Md		25a. DATE REC'D. BY REGISTRAR FEB 3 1984		25b. REGISTRAR'S SIGNATURE John J. Conner						

BP



Info	Office	+	IN	OR	SI
Henry	F.B.I.	-	-	-	F.B.I. - New York
Mr. T. J. Ryan	F.B.I.	-	-	-	F.B.I. - New York
Mr. J. Edgar Hoover	F.B.I.	-	-	-	F.B.I. - New York
Mr. J. Edgar Hoover	F.B.I.	-	-	-	F.B.I. - New York

RECEIVED - NEW YORK - MAY 15 1964

TO : DIRECTOR, FBI (100-371091)
FROM : SAC, NEW YORK (100-371091)
SUBJECT: [Illegible]
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03193

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Lloyd Hopkins			2a. DATE OF DEATH MONTH DAY YEAR 2-22-84		2b. HOUR MIN. 8:50 P
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 8-05-02	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HAAGEN Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			
13a. STATE MD.		13b. COUNTY ANNE A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 208 H KENDREE AVE 21401
14. FATHER'S NAME FIRST MIDDLE LAST Robert Ridgely Hopkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Lloyd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) 1920-1938		17. INFORMANT ADDRESS Blanche Wayson Hopkins #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brown Stem herniation. 8842 DUE TO, OR AS A CONSEQUENCE OF (b) Subdural hematoma DUE TO, OR AS A CONSEQUENCE OF (c) fall Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Senile Dementia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 2:20 PM pain to elbow	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) fell out of Bed		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 703 GIDDINGS AVE ANNAPOLIS MD		
22a. I certify that (a) (this hospital) attended the deceased from 2/19 19 84 , to 2/22 19 84 , that (b) (we) last saw the deceased alive on 2/21 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael J. LaPenta MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MILHAEL J. LaPenta		22e. ADDRESS 703 GIDDINGS AVE ANNAPOLIS MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb 24, 1984	23c. NAME OF CEMETERY OR CREMATORY Glen Haven	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD		
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis, MD		25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall	

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03194

1- FOR
STATE
REGISTRAR

REG. NO.

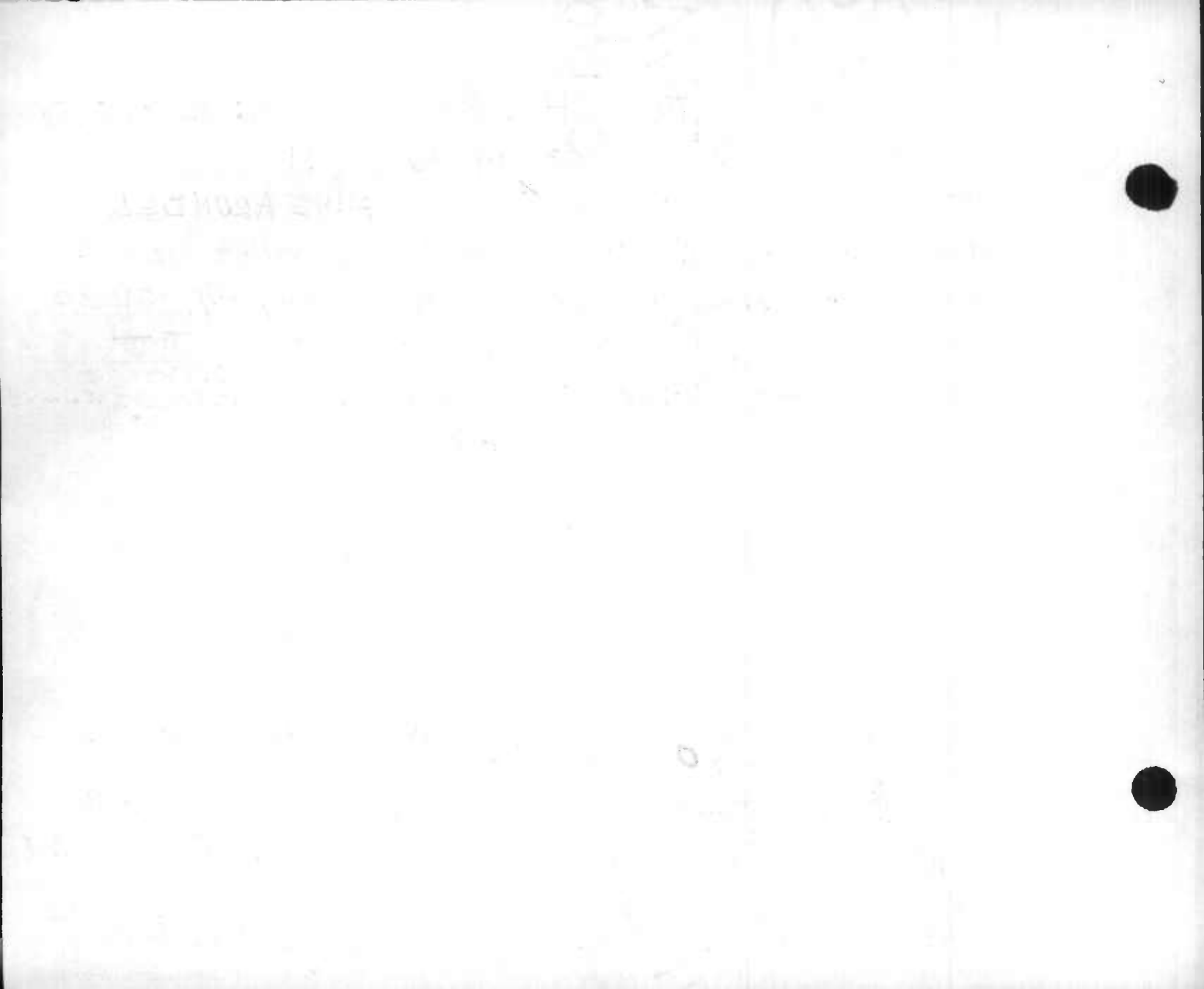
1. DECEASED NAME (TYPE OR PRINT) JOSHUA T HOWES			2a. DATE OF DEATH MONTH DAY YEAR 02-05-84			2b. HOUR 7:45 PM				
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 08 14 92		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Gov Ret		12b. KIND OF BUSINESS OR INDUSTRY mechanic		
13a. STATE MARYLAND			13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN CHURCHTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 74, 21032	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Howes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Victoria Trott			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 216-01-4915			17. INFORMANT Marie Sutphin			ADDRESS 215B Farncroft Ct Annapolis MD 21403				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured AAA. 4413 DUE TO, OR AS A CONSEQUENCE OF (b) HARENO DUE TO, OR AS A CONSEQUENCE OF (c) COPD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/30/84 to 2/5/84, that (II) (we) lost saw the deceased alive on 4/30/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE M. J. J. J. J.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL J. La Penna			22e. ADDRESS 703 GIDDINGS AVE ANNAPOLIS MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-8-84		23c. NAME OF CEMETERY OR CREMATORY Friendship		23d. LOCATION CITY OR TOWN COUNTY STATE Friendship AA MD			
24. FUNERAL DIRECTOR NAME Roboch Funeral Home			ADDRESS OWINGS MD			25a. DATE RECEIVED BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S NAME John S. J. J.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03195			
1. DECEASED NAME (TYPE OR PRINT) JOSEPH EDWARD A. HUDGINS				2a. DATE OF DEATH MONTH DAY YEAR 2-28-84				2b. HOUR 12:45 P.M.			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 25 97		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 1 YEAR HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD					
12. CITY OR TOWN OF DEATH Glen Burnie		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 524 Munroe Circle 21061				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		15. KIND OF BUSINESS OR INDUSTRY B&O R.R.			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD. 16b. COUNTY A.A. Co. 16c. CITY OR TOWN Glen Burnie				17. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 524 Munroe Cir. 21061					
19. FATHER'S NAME FIRST MIDDLE LAST JOHN SEBASTIAN HUDGINS				20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORNELIA G. BROOKS							
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				22. SOCIAL SECURITY NO. 705 05 3091		23. INFORMANT ADDRESS ROBERT HUDGINS 524 Munroe Cir.					
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4960 Acute Respiratory Failure IMMEDIATE CAUSE (a) Chronic Obstructive lung disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Diabetes Mellitus and Arteriosclerosis Heart Disease											
25. DATE OF OPERATION				26. CONDITION FOR WHICH OPERATION WAS PERFORMED				27. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
32. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				33. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE					
35. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 2-31-84 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
36. SIGNATURE Aljandrio Montoya				37. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				38. DATE SIGNED 2-28-84			
39. PHYSICIAN'S NAME (TYPE OR PRINT) ALEJANDRIO MONTOYA M.D.				40. ADDRESS 7345 OAKWOOD RD. GLEN BURNIE, Md. 21061							
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				42. DATE 3-2-84		43. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		44. LOCATION (CITY OR TOWN) COUNTY STATE Balto. Co Md.			
45. FUNERAL DIRECTOR NAME Raymond C. Fink				46. ADDRESS Glen Burnie, Md.		47. DATE REC'D. BY REGISTRAR FEB 29 1984		48. REGISTRAR'S SIGNATURE Lia Davidson-Rendell			

BP _____

FIBER

CHINA



FEB 23 1984

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			20. DATE KNOWN OF DEATH			21. DATE OF DEATH			22. DATE OF DEATH			23. DATE OF DEATH			24. DATE OF DEATH		
George L. Irwin			20. DATE KNOWN OF DEATH 2 27 84			21. DATE OF DEATH 2 27 84			22. DATE OF DEATH 2 27 84			23. DATE OF DEATH 2 27 84			24. DATE OF DEATH 2 27 84		
3. SEX Male			4. RACE White			5. DATE OF BIRTH 4 25 15			6. AGE (IN YEARS) 68 YRS.			7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel			10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 213 West Hilltop Road		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist			12b. KIND OF BUSINESS OR INDUSTRY Railroad			13a. STATE Md			13b. CITY OR TOWN A.A.			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME George A. Irwin			15. MOTHER'S MAIDEN NAME Emma L. Leckheim			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 163-18-7888			17. INFORMANT Robert G. Irwin			18. ADDRESS Maryland 21061 509 Kent Rd, Glen Burnie		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart attack</u> 4280 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Chr. cong. failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			22b. TITLE (SPECIFY) M.D. Deputy			22c. DATE SIGNED 2-27-84		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/1/84			23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park			23d. CITY OR TOWN Dorsey			23e. COUNTY Howard			23f. STATE Md		
24. FUNERAL DIRECTOR NAME George J. Gonce			4001 Ritchie Hgwy Balto, Md			25a. DATE REC'D. BY REGISTRAR MAR 1 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			25c. DATE REC'D. BY REGISTRAR MAR 1 1984			25d. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

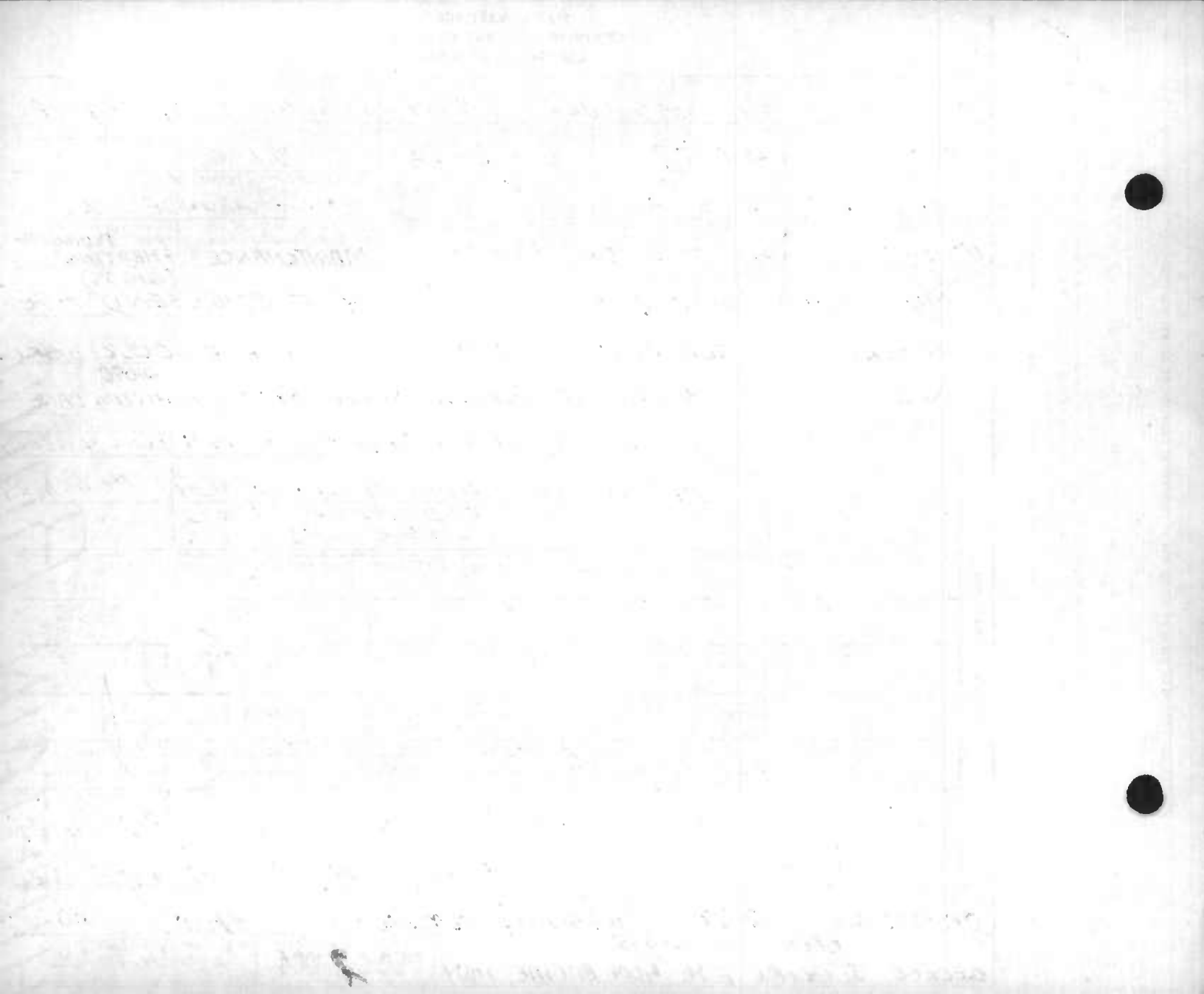
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03197

1. DECEASED NAME (TYPE OR PRINT) MICHAEL THOMAS JEFFERSON			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 23, 1984			2b. HOUR 7:10 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2-16-13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.	
10. CITY OR TOWN OF DEATH BROOKLYN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 415 TOWNSEND AVE.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE	
12b. KIND OF BUSINESS OR INDUSTRY PLUMBING		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY AA CO.		13c. CITY OR TOWN BROOKLYN	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 415 TOWNSEND AVE (21225)		14. FATHER'S NAME FIRST MIDDLE LAST ALBERT JEFFERSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA JOSEPHINE OLSZEWSKI	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-05-4575		17. INFORMANT ADDRESS 21090 CAROLYN KEEFE 5925 LINTHICUM LANE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALNUTRITION - DEHYDRATION OVER 4 WEEKS 1509 DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF ESOPHAGUS WITH WIDESPREAD METASTASES (LIVER, CHEST, ETC.) 14 MONTHS DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from APRIL 19 81, to FEB 23, 19 84, that (I) (we) lost saw the deceased alive on FEB 22, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. A. ALONSO, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. A. ALONSO				22e. ADDRESS 1406 CRAN HIGHWAY, G.B.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2-27-84		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME BALTO., MD. 21225 GEORGE J. GONCE F.H. 4001 RITCHIE HWY				25a. DATE REC'D. BY REGISTRAR FEB 27 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	EST
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOUIS Walter JOHNSON, Jr.			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 8, 1984		2b. HOUR A M 7:30 A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 14, 1952		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY Disabled
13a. STATE Md.			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena	
14. FATHER'S NAME FIRST MIDDLE LAST Louis A. Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Druilla E. Henderson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-82-7411		17. INFORMANT ADDRESS Louis A. Johnson same as 13 E		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4850 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Severe Kyphoscoliosis</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>2-8</u> , 19 <u>84</u> , to <u>2-8</u> , 19 <u>84</u> , that (we) last saw the deceased alive on <u>2-7</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.						
22b. SIGNATURE Edward Sherman		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-8-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD N. SHERMAN, M.D.		22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-11-84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.
24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home		ADDRESS 3204 Mountain Rd. 21122		25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03199			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OTH O JOHNSON, Sr.				2a. DATE OF DEATH MONTH DAY YEAR 2 6 84			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 3 12 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GAMBRILLS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1117 North Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN GAMBRILLS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE QUEEN		13e. STREET ADDRESS 1117 North Lane 21054			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HAZEL R. JOHNSON 1117 North Lane Gambrills, Md. 21054			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Carcinoma Colon = metastases - mmts. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6 Feb 84, 19 84, to 6 Feb 84, 19 84, that I (we) lost s/he the deceased alive on 6 Feb 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William H Choate MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8 Feb 84.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H. CHOATE, M.D.				22e. ADDRESS 2083 West Street, Annapolis, MD 21401			
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL		23b. DATE 2-9-1984		23c. NAME OF CEMETERY OR CREMATORY St. John A.M.E. Church		23d. LOCATION CITY OR TOWN COUNTY STATE Odenton A.A. Maryland	
24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401				25a. DATE REC'D. BY REGISTRAR FEB 10 1984		25b. REGISTRAR'S SIGNATURE J. C. C.	

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DATE: 10/10/1941
TO: THE DIRECTOR, AIR CORPS
FROM: THE DIRECTOR, AIR CORPS
SUBJECT: [illegible]

RE: [illegible]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) QUEEN JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 29, 1984			2b. HOUR 640 am				
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7-12-1901		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD				
12. CITY OR TOWN OF DEATH GLEN BURNIE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Md.			16b. COUNTY 17		16c. CITY OR TOWN Baltimore		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 501 Dolphin St. 21217	
17. FATHER'S NAME FIRST MIDDLE LAST James			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma							
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			19b. SOCIAL SECURITY NO. 219-22-6815		19c. INFORMANT Grant Johnson		19d. ADDRESS S/A			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive heart disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Arteriosclerosis - Arteriosclerosis - Arteriosclerosis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED HOMILE <input type="checkbox"/> HOSPITAL <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1/31/84 to 2/29/84 , that (I) (we) last saw the deceased alive on 2/28/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (they) did not view the body after death, so state.)										
22b. SIGNATURE Dr. J. B. Manning						DEGREE MD		22c. DATE SIGNED 2/29/84		
22d. PHYSICIAN'S NAME (Print or Print) Dr. J. B. Manning						22e. ADDRESS 7845 OAKWOOD ROAD SUITE 205 GLEN BURNIE, MARYLAND 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-7-84		23c. NAME OF CEMETERY OR CREMATORY Manning Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Manning Baltimore MD		
24. FUNERAL DIRECTOR NAME Brown/Thompson F.H.			ADDRESS 1913 W. Balto. St. Balto. Md. 21223			25a. DATE REC'D. BY REGISTRAR MAR 06 1984		25b. REGISTRAR'S SIGNATURE Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 4 and 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified to examine the body.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and page 4 must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>SARAH J KEATS</u>					2a. DATE OF DEATH MONTH <u>02</u> DAY <u>23</u> YEAR <u>84</u> 2b. HOUR <u>12:40AM</u>				
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>01</u> DAY <u>03</u> YEAR <u>16</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>68</u> YRS.		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> HOURS <u> </u> MIN. <u> </u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel Co., MD.</u>			
10. CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel General Hospital Retired</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Civil Service</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>MD</u>		13b. COUNTY <u>A.A.</u>		13c. CITY OR TOWN <u>Annapolis</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>245-A Boxwood Road 21403</u>	
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>Powell</u> LAST <u>Unknown</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Unknown</u> MIDDLE <u> </u> LAST <u> </u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			
16b. SOCIAL SECURITY NO. <u> </u>			17. INFORMANT <u>Emmet Douglas Keats Annapolis, MD 21401</u>			ADDRESS <u>636 Broadneck Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> <u>5570</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METABOLIC ACIDOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MESENTERIC VASCULAR OCCLUSION</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>36 HRS.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>RHEUMATIC HEART DISEASE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>JAN 1</u> , 19 <u>83</u> , to <u>FEB 23</u> , 19 <u>84</u> , that (1) (we) lost saw the deceased alive on <u>FEB 22</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Barry R. Nathanson MD</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2/23/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRY R. NATHANSON</u>					22e. ADDRESS <u>51 FRANKLIN ST ANNAP, MD 21401</u>				
23a. BURIAL, CREMATION, REMOVAL (RECORD) <u>Burial</u>		23b. DATE <u>Feb. 25, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION CITY OR TOWN <u>Brooklyn, A.A.</u> COUNTY <u>MD</u> STATE <u>MD</u>			
24. FUNERAL DIRECTOR NAME <u>Taylor Funeral Chapel - Annapolis, MD</u> ADDRESS <u> </u>					25a. DATE REC'D. BY REGISTRAR <u>FEB 28 1984</u>		25b. REGISTRAR'S SIGNATURE <u> </u>		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Henry Evans Keck			2a. DATE OF DEATH MONTH DAY YEAR Feb 29, 84			2b. HOUR 7:30 A.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 29, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) San Pedro Calif		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1117 Kalmia Ct.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) manager	
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wilburn Leslie				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elin Gordon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 1961-1981 252-62-1183		17. INFORMANT ADDRESS 1117 Kalmia Ct. Jeanne G. Keck Crownsville, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1890 IMMEDIATE CAUSE (a) <u>Cardiopulmonary Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Renal Cell Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 17 months
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	---------------------------------------------------------------------------

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>82</u> , to <u>29 Feb</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>27 Feb</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William GENT, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>29 Feb 84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William GENT</u>				22e. ADDRESS <u>Dept. of Medicine Washington, D.C. 20042</u> <u>V.A. Medical Center 50 Irving St N.W.</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/1/84		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.	
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home				12 ADDRESS Ridgely Ave. Annapolis, Md.		25a. DATE REC'D. BY REGISTRAR MAR 1 1984	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBRE

CHICKEN MANURE



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE1- FOR
STATE REGISTRAR HOWARD MILBOURNE KELLEY CERTIFICATE OF DEATH

REG. NO.

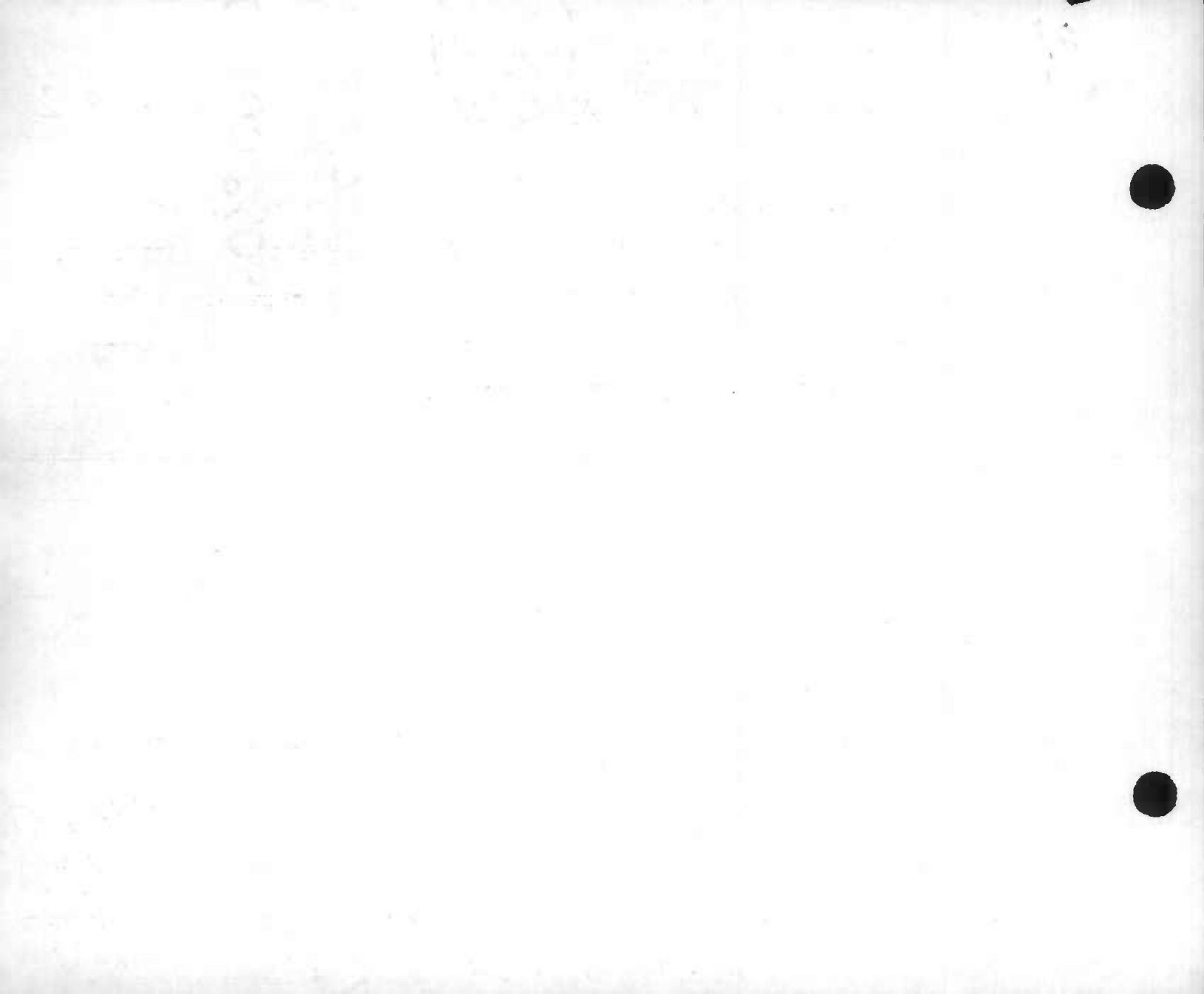
1. DECEASED NAME (TYPE OR PRINT) Howard M. Kelley		2a. DATE OF DEATH MONTH DAY YEAR 2-1-84		2b. HOUR 3:03 a.m.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 4-19-25		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SALISBURY, MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY MFGRS. REP.
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD YEWINGS KELLEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA MORRIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. W.W. II 213.14.1275		17. INFORMANT LUCILLE L. KELLEY	
				ADDRESS SAME AS 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death: 3 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/30 19 84 , to 2/1 19 84 , that (I) (we) lost saw the deceased alive on 1/30 19 84 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Enser W Cole		DEGREE MD		22c. DATE SIGNED 2/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E COLE		22e. ADDRESS 57 FRANKLIN ANNAPOLIS Md 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2/2/1984		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222			
25a. DATE REC'D. BY REGISTRAR FEB 2 1984		25b. REGISTRAR'S SIGNATURE John J. Carney			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03204

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CARL R. KESTER			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 16, 1984		2b. HOUR 6:40 AM		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 25, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 300 ST. BEES DR		13f. ZIP CODE 21146		14. FATHER'S NAME FIRST MIDDLE LAST IRVIN KESTER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PRISCILLA EGNAR	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT PRISCILLA LYMAN		ADDRESS (SAME AS 13)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 2399 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tumor DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 2/15/84 to 2/16/84 , that (I) (we) last saw the deceased alive on 2/15/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE James G. Chaconas		DEGREE MD PA		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James G. Chaconas, MD PA		22e. ADDRESS 1521 Ritchie Hwy, Arnold, MD 21012					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 20, 1984		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SERVIA WABASH IND.	
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME		ADDRESS 501 RITCHIE HWY SEVERNA PARK, MD.		DATE REC'D. BY REGISTRAR FEB 21 1984		REGISTRAR'S SIGNATURE J. Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

1

Handwritten notes and a table at the top of the page. The table has several columns and rows of text, which is mostly illegible due to fading. There are some words like "Date" and "Description" visible in the header.

Handwritten notes in the middle section of the page, continuing the entries from the table above. The text is written in cursive and is mostly illegible.

Handwritten notes at the bottom of the page, including a date "FEB 1901" and some other illegible text.

1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE JANE LAST KINZER			2a. DATE OF DEATH MONTH 2 DAY 8 YEAR 84		2b. HOUR A. M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Sept. DAY 7 YEAR 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Real Estate
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 21403 3059 Mimin Road	
14. FATHER'S NAME FIRST Thomas MIDDLE SUTHERS LAST		15. MOTHER'S MAIDEN NAME FIRST Edna MIDDLE Jane LAST Linkous			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO, IF UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-32-6567		17. INFORMANT ADDRESS Charles W. Kinzer Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension 4029					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIAC DECOMPENSATION					
DUE TO, OR AS A CONSEQUENCE OF (c) AFIB/ NCLD					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (CUPD, Sterile Blain Syndrome)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 66, to present, 19 84, that (I) (we) lost saw the deceased alive on 2/5 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE A. Bern		DEGREE		22c. DATE SIGNED 2/8	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Biern, MD		22e. ADDRESS 51 Franklin St, Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 10, 1984		23c. NAME OF CEMETERY OR CREMATORY Fairview	
23d. LOCATION CITY OR TOWN COUNTY STATE Roanoke Roanoke VA		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 9 1984 John J. Carver			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				EST			
1. FOR STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT) JAMES HYDEN KNIGHT SR					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 03, 1984				2b. HOUR 1644 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 20 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.						
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OR PRINT) (WORKING LIFE) (deceased) mechanic		12b. KIND OF BUSINESS OR INDUSTRY State RdsCom.				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.					13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 510 Evelyn Ave. 21061	
14. FATHER'S NAME (FIRST MIDDLE LAST) James Barnes Knight					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Mary Elizabeth Byrd							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. Na		17. INFORMANT (NAME AND ADDRESS) (daughter) 112 First Ave. S. Bertha J. Johnson Ferndale G. Burnie 21061 Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4960 Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Lung Disease</u>										18b. APPROXIMATE INTERVAL (IN YEARS) BETWEEN ONSET AND DEATH years year year		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>examine the body after death.</u>												
22b. SIGNATURE <u>Dr. Sang Doi</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 2-4-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SANG DOI								22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6 Feb. 84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.				
24. FUNERAL DIRECTOR NAME Singleton Funeral Home Glen Burnie Md.				24b. ADDRESS Glen Burnie Md.		25a. DATE REC'D. BY REGISTRAR FEB 7 1984		25b. REGISTRAR'S SIGNATURE J. C. Carroll				

BP

FILED



RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

Re New York letter to Bureau dated 1/8/64.
Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.
The LHM contains information received from [Illegible] regarding [Illegible].
Very truly yours,
[Illegible Signature]
Special Agent in Charge

Enclosure
JAN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

FILED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

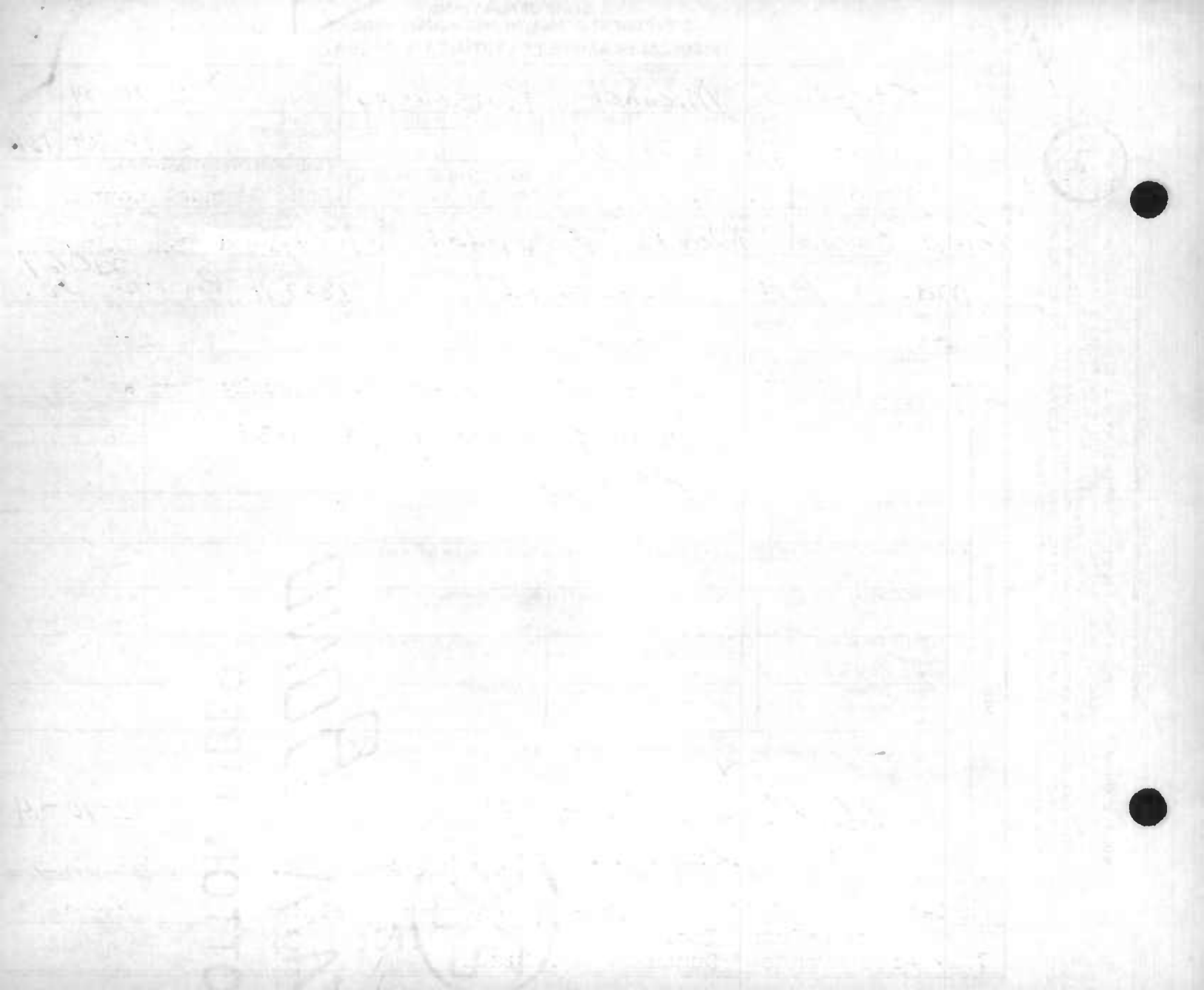
DHMH - 17
(VR A15 ME (5))
20M 4/82

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Stephen Michael Kolsousky			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 2 10 84			2b. HOUR 1348		
3. SEX M	4. RACE CAU	5. DATE OF BIRTH MONTH 08 DAY 18 YEAR 22	6. AGE (IN YEARS) LAST BIRTHDAY 61 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD 2 10 84		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD		
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Expeditor - Glen L. Martin		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE MD.			13b. COUNTY A.A.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST John MIDDLE Kolsousky LAST Kasta			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Kasta LAST Kasta			16. SOCIAL SECURITY NO. 183-14-4525		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 183-14-4525			17. INFORMANT ADDRESS Dorothy I. Kolsousky Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) AS HD. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE William P. Jones, M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.			ADDRESS 695 America Ct. Davidsonville 21035					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/15/1984		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222			25a. DATE BY REGISTRAR FEB 14 1984			25b. REGISTRAR'S SIGNATURE Gina Davidson-Yendall		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03208

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dorothy Day Kreuzburg			2a. DATE OF DEATH MONTH DAY YEAR 2 9 84			2b. HOUR 130 P.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 1 23 15		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GEN.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER	
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN EDGEWATER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN DAY GREEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SUE TANSILL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-62-0381	
17. INFORMANT ADDRESS MR. DAY KREUZBURG		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brady arrhythmia & Respiratory arrest 4960 DUE TO, OR AS A CONSEQUENCE OF (b) Acute & Chronic Respiratory failure 8 days DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Pulmonary Disease YEARS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 YEARS		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) the deceased attended the deceased from 2/15 to 2/19 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE Krimins		22c. DATE SIGNED 2/19/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRIMINS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 2/11/1984		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.	
24. FUNERAL DIRECTOR NAME John A. F. 254 Carroll St. N.W. Washington D.C.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Davidson-Randall		25c. DATE REC'D. BY REGISTRAR	

MEDICAL CERTIFICATION

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

HYPERTENSION, ELECTROLYTE IMBALANCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

1

WASHINGTON, D.C. 20540
JAN 21 1971
38 VIRGINIA AVENUE
ARLINGTON, VIRGINIA 22204

JOHN JAY GREEN
2502-2501 BR. DAVENPORT ST. SILVER SPRING, MD.
TAN 5114

2502-2501 BR. DAVENPORT ST. SILVER SPRING, MD.
JAN 21 1971

WASHINGTON, D.C. 20540
JAN 21 1971

38 VIRGINIA AVENUE
ARLINGTON, VIRGINIA 22204

WASHINGTON, D.C. 20540
JAN 21 1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Rita M. Laughlin				2a. DATE OF DEATH MONTH DAY YEAR February 21, 1984			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 12, 1988		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 755 222nd St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY St. Ann's Hosp.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Montana		13b. COUNTY Deer Lodge		13c. CITY OR TOWN Anaconda		13e. STREET ADDRESS 420 W. 4th St. 59711 99999	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Egan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae Unk.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 517-24-2313		17. INFORMANT ADDRESS Marita Rey 755 222nd St. Pas., Md. 21122			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 4920 DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 2/20/84 to 2/21/84 , that (I) (we) last saw the deceased alive on 2/20/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. Gorbaty				DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. GORBATY				22e. ADDRESS 7845 OAKWOOD RD, GLEN BURNIE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-25-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anaconda Deer Lodge Mont.	
24. FUNERAL DIRECTOR NAME Mc Gully Funeral Home ADDRESS 3204 Mountain Rd. 21122				25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE	

999999 BP

011111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M/7/77
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Eva Day Leebrick					2a. DATE OF DEATH MONTH DAY YEAR Feb. 26, 1984			2b. HOUR 5:05P M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 9, 1983		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alpine Calif.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Nursing and Convalescent				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY household	
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 798 Oak Lane 21401	
14. FATHER'S NAME FIRST MIDDLE LAST Herbert J. Day					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Wenthner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS J., Paul Leebrick Jr. 798 Oak Lane Annapolis, Md. 21401					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of the Colon</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Charles W. Finer					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 2/28/84		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. A.A. Co.		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home					ADDRESS 12 Ridgely Ave. Annapolis, Md. 21401		25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

MEDICAL CERTIFICATION

NOTED & CO.



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NOTED & CO.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1 - STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <i>Amelia E. LeMoine</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>February 27 1984</i>					2b. HOUR M				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 2, 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel</i> MD.								
10. CITY OR TOWN OF DEATH <i>Anne Arundel</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>105 Walton Ave</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>						
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Anne Arundel</i>		13c. CITY OR TOWN ---		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>105 Walton Ave 21225</i>						
14. FATHER'S NAME FIRST MIDDLE LAST <i>Earl Langford</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Frances Pottee</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-22-0589</i>		17. INFORMANT <i>Mrs. Victory Stinchomb</i>		ADDRESS <i>17 Montrose Road Pasedena, Md. 21122</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>generalized carcinomatous</i> <i>1749</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ca l breast</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____														
19a. DATE OF OPERATION <i>1979</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <i>79</i> , to <i>Feb</i> 19 <i>84</i> , that (I) <i>have</i> lost saw the deceased alive on <i>Nov. 30</i> 19 <i>83</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>will</i> (did) view the body after death.														
22b. SIGNATURE <i>Philip W. Keister, M.D.</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/28/84.</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Philip W. Keister</i>					22e. ADDRESS <i>302 Patapsco Ave. Baltimore, Md. 21225</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>March 1, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery BAIT.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bait. Anne Arundel MD.</i>								
24. FUNERAL DIRECTOR NAME <i>McGully Funeral Home</i>					ADDRESS <i>237 E Patapsco Ave. BAIT. MD 21225</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 28 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03212

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Wade Michael Liminy			2a. DATE KNOWN OF DEATH 2/26/84 19			2b. HOUR 11:56 A M		
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH 9-26-59	6. AGE (IN YEARS) 24	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 2/26/84 19		
7a. BIRTHPLACE (STATE OR) WASHINGTON		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD		
10. CITY OR TOWN OF DEATH Riva		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Riva Rd. Bridge over S.Riva River				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND ANNE ARUNDEL			13b. CITY OR TOWN RIVA		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3112 SHREWSBURY LANE 21140	
14. FATHER'S NAME FIRST MIDDLE LAST GARY D. LIMING			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEAN D. KINZEL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 368-72-7700		17. INFORMANT ADDRESS GARY D. LIMING SAME AS 13E		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:40 PM 2/26/84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of auto, struck rail, blundged into river				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) river		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Riva Rd. Bridge, So. River, Riva, Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Ann M. Dixon</i>		TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 2/27/84		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-3-84		23c. NAME OF CEMETERY OR CREMATORY RITZVILLE CEMETERY RITZVILLE		23d. LOCATION CITY OR TOWN COUNTY STATE ADAMS CO. WASHINGTON		
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS		ADDRESS ANNAPOLIS, MARYLAND		25a. DATE REC'D. BY REGISTRAR MAR 1 1984		25b. REGISTRAR'S SIGNATURE ton		

FILE 27

1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Ida Marie Lindemann			2a DATE OF DEATH MONTH DAY YEAR February 23, 84			2b HOUR 10 am			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MO: DAY YEAR April 20, 1915		6 AGE (IN YEARS LAST BIRTHDAY) 68		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MDX - Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10 CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crownsville Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b KIND OF BUSINESS OR INDUSTRY own home			
13a STATE MD		13b COUNTY AA		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS 1530 Furnace Ave 21061			
14 FATHER'S NAME FIRST MIDDLE LAST Edward Merson			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Englemann			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO			
16b SOCIAL SECURITY NO. XXXXXXXX 213/18/6924			17 INFORMANT ADDRESS Same as 13			17 Jeannette Ringrose (daughter)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Dehydration DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Fever of unknown origin; Decubitus on sacrum; Schiz., C.U.T.									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/13 , 19 78 , to 2/23 , 19 84 , that (I) (we) last saw the deceased alive on 2/23 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Eugene</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/23/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Eugene - CR44, MD.		22e ADDRESS Crownsville Hosp Center Crownsville Md. 21032							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 25 Feb. 1984		23c NAME OF CEMETERY OR CREMATORY Glen Haven Mem Pk		23d LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD			
24 FUNERAL DIRECTOR'S NAME Singleton Funeral Home, Glen Burnie, MD				25a DATE REC'D. BY REGISTRAR FEB 24 1984		25b REGISTRAR'S SIGNATURE <i>Lisa Davidson-Randall</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs 4 days or more after death, the certificate must be signed by the attending physician. The law requires that the death certificate be executed within 24 hours after death. If the death occurs 4 days or more after death, the certificate must be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03214

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALOYSIUS J. LITTLE			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 18, 1984			2b. HOUR 9:32P ^M	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 9-27-96	6. AGE (IN YEARS (LAST BIRTHDAY)) 87		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK, TRADE, VOCATION, BUSINESS, OR INDUSTRY) INSPECTOR		12b. KIND OF BUSINESS OR INDUSTRY ANNE ARUNDEL COUNTY		
13a. STATE MARYLAND			13b. COUNTY ANNAPOLIS		13c. CITY OR TOWN ANNAPOLIS		
14. FATHER'S NAME JOSEPH LITTLE		15. MOTHER'S MAIDEN NAME ELEANOR UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO		16b. SOCIAL SECURITY NO. 220-30-0012		17. INFORMANT ADDRESS MARY ELEANOR CRUTCHLEY 726 GLENWOOD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchogenic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>STREET ANNAPOLIS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK WHILE <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, TRAM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 17</u> 19 <u>84</u> to <u>Feb 18</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Feb 17</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)							
22b. SIGNATURE <u>William C. Weintraub</u>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM C. WEINTRAUB, M.D.		22e. ADDRESS 104 FORBES ST. ANNAPOLIS	
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 2-22-84		23c. NAME OF CEMETERY OR CREMATORY ST. MARYS CEMETERY		23d. LOCATION ANNAPOLIS ANNE ARUNDEL CO	
24. FUNERAL DIRECTOR ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS		25a. DATE REC'D. BY REGISTRAR FEB 21 1984		25b. REGISTRAR'S SIGNATURE <u>Gina Davidson-Randell</u>			

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified for once.

1 - STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03215

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLOTTE J LOVE			2a. DATE OF DEATH MONTH DAY YEAR 2/12/84		2b. HOUR MIN. 4:35 AM		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUG 12 1924		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 59	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOSTESS		12b. KIND OF BUSINESS OR INDUSTRY RESTURANT	
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ARNOLD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DELBERT McCUE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES		13e. STREET ADDRESS / ZIP CODE 740 DIVIDING CREEK RD. 21012			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 384161354		17. INFORMANT ADDRESS ROBERT C. BRINKMAN (SAME AS 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the Vagina 1840 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 2/11 19 84 , to 2/12 19 84 , that (1) (we) last saw the deceased at 2/11 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If "we" checked, did not view the body after death.)							
22b. SIGNATURE James Chaconas		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Chaconas		22e. ADDRESS 1521 Ritchie Hwy Arnold, MD 21012					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE FEB. 14, 1984		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WESTVIEW BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO		501 RITCHIE HWY SEVERNA PARK, MD		25a. DATE REC'D. BY REGISTRAR FEB 16 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

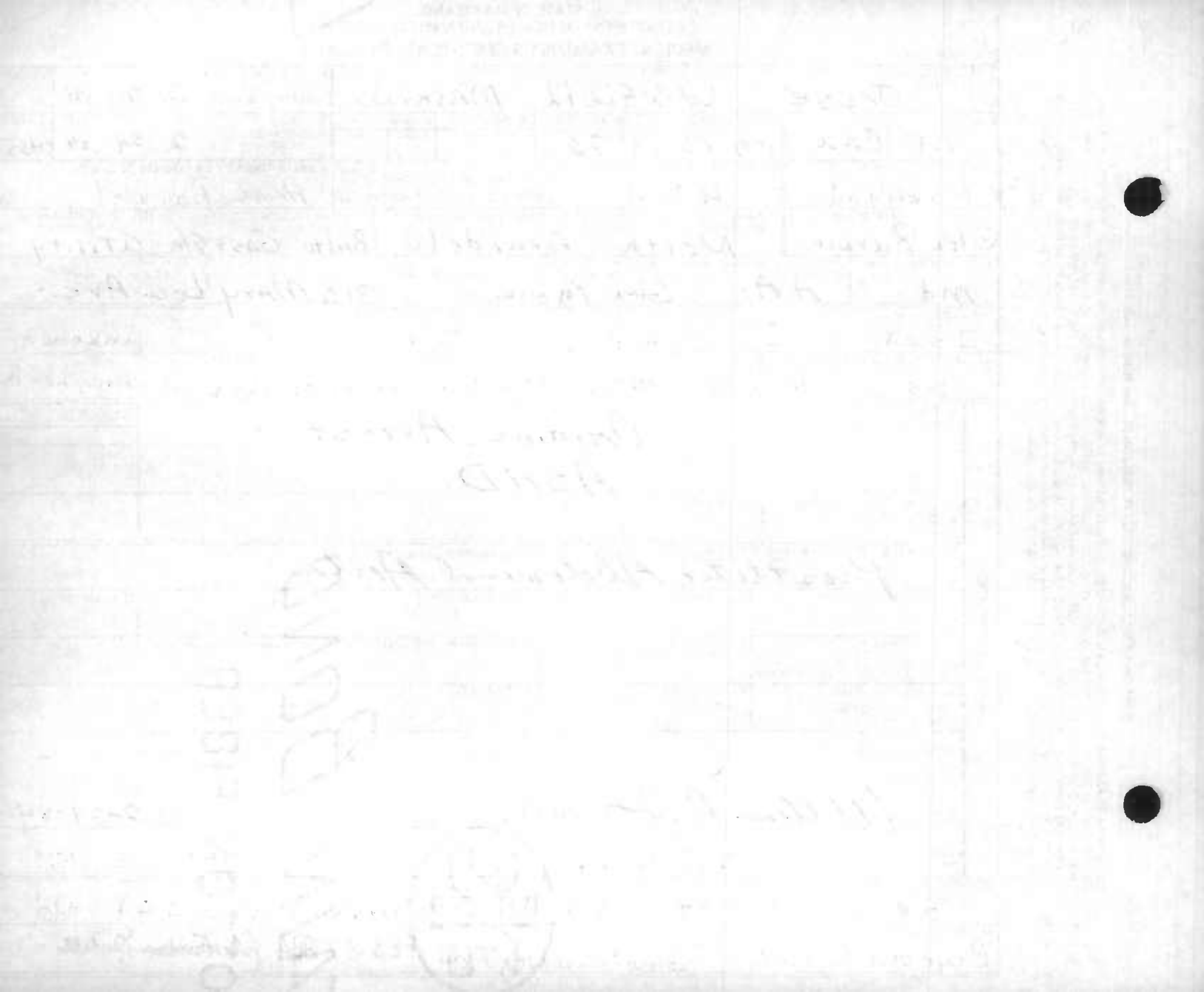
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry C. Luther			2a. DATE OF DEATH MONTH DAY YEAR 2-12-84		2b. HOUR 10:29 AM		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 7 12 98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Severna Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nsg. Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) plant manager		12b. KIND OF BUSINESS OR INDUSTRY WHITBOARD FACTORY	
13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK LUTHER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN)		13e. STREET ADDRESS / ZIP CODE 1873 American Circle Apt. 12 21061			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 105-09-6986		17. INFORMANT DONALD L. LUTHER		ADDRESS SEVERNA PARK, MD 21146	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>RESPIRATORY ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRO-VASC. ACCIDENT</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>CVA. 1982</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this physician attended the deceased from <u>JULY 19 82</u> to <u>2/12 19 84</u> , that (1) <u>last</u> saw the deceased alive on <u>2/7 19 84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>did</u> (2) <u>did not</u> view the body after death.							
22b. SIGNATURE <u>Dr. Zimmerman</u>				22c. DEGREE <u>MD</u>		22d. DATE SIGNED <u>2/12/84</u>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. ZIMMERMANN</u>				22f. ADDRESS <u>200 HOSPITAL DR. GLEN. B. 21061</u>			
23a. BURIAL, CREMATION, REMOVAL SPECIES <u>CREMATION</u>		23b. DATE <u>FEB. 14, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTVIEW CREMATORY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>WESTVIEW BALTIMORE MD</u>	
24. FUNERAL DIRECTOR NAME <u>ROBERT S. BARRANCO</u>				25a. DATE REC'D. BY REGISTRAR <u>FEB 16 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Jesse Winfield MACKINS							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR		
3. SEX M		4. RACE CAU		5. DATE OF BIRTH MONTH 09 DAY 13 YEAR 13		6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEATH MONTH 2 DAY 24 YEAR 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Balto Gas & Elec		12b. KIND OF BUSINESS OR INDUSTRY Utility	
13a. STATE md				13b. COUNTY AA.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 313 Mary Lou Ave.	
14. FATHER'S NAME FIRST Isiah MIDDLE - LAST Mackins						15. MOTHER'S MAIDEN NAME FIRST DORA MIDDLE - LAST unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. W.W.II		17. INFORMANT Barbara G. Mackins		ADDRESS 313 Mary Lou Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASHD. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 (OTHER SIGNIFICANT) CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Prosthetic Abdominal Aorta											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE William P. Jones, M.D.				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 2-24-84			
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.				ADDRESS 695 America Ct Davidsonville 21035							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-27-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn (A.A.) Md.	
24. FUNERAL DIRECTOR NAME Raymond C. Fink ADDRESS Glen Burnie, Md.						25a. DATE REC'D. BY REGISTRAR FEB 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

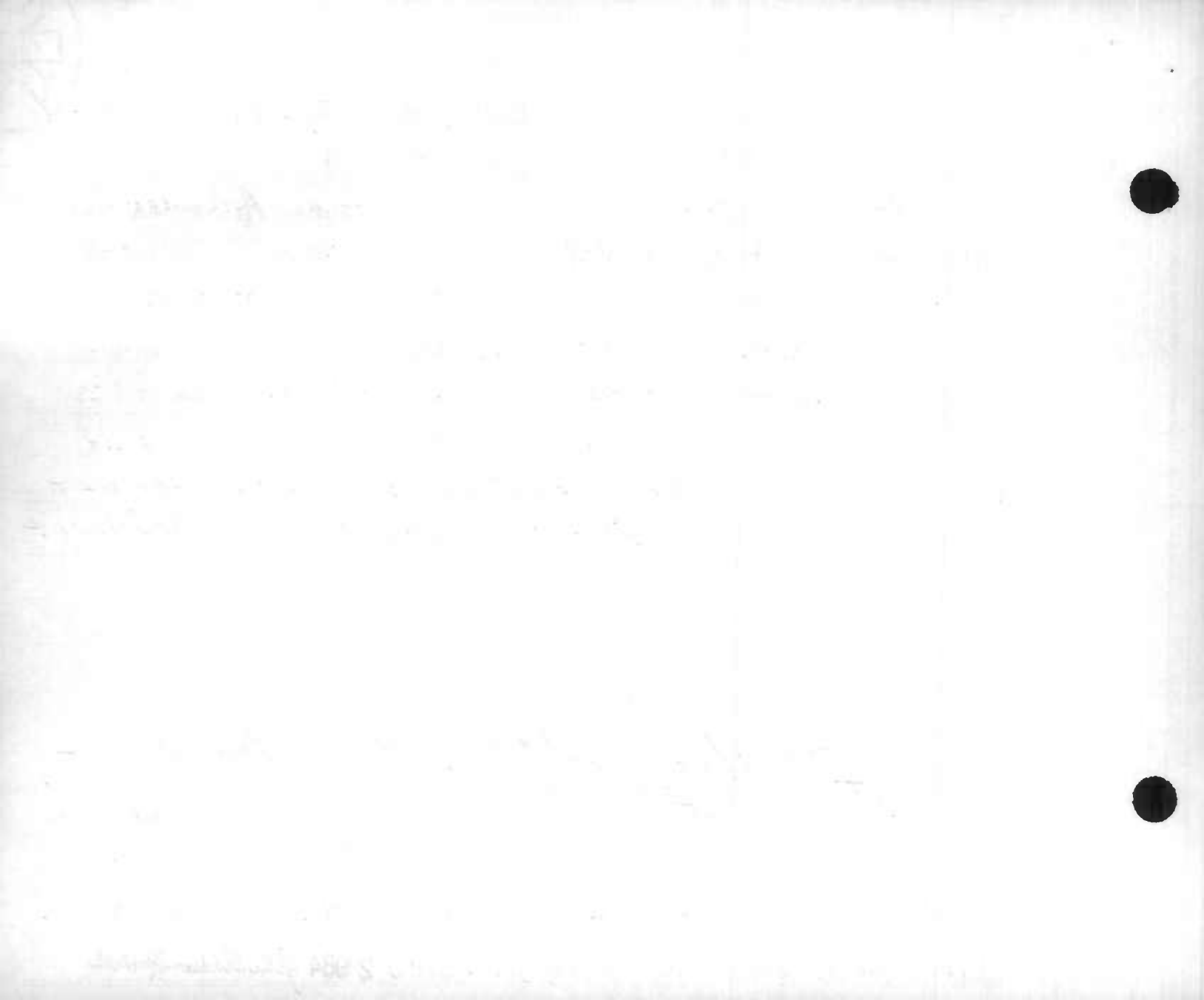
03218

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James W Marshall, SR.			2a. DATE OF DEATH MONTH DAY YEAR 2/24/84			2b. HOUR 9:25 PM				
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 09 08		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman		12b. KIND OF BUSINESS OR INDUSTRY Seafood		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Deale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 614 Marshall Street 20751	
14. FATHER'S NAME FIRST MIDDLE LAST James Morris Marshall			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violetta Rogers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-16-3132		17. INFORMANT ADDRESS James W. Marshall, Jr. Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4241 DUE TO, OR AS A CONSEQUENCE OF (b) <u>THROMBIC + MITRAL VALVE DISEASE</u> 40 yrs + DUE TO, OR AS A CONSEQUENCE OF (c) <u>RHEUMATIC FEVER</u> 40 years +								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the physician) attended the deceased from <u>1984</u> , to <u>2/24</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Harvey J Steinfeld MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/26/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harvey J Steinfeld			22e. ADDRESS 3 Harbyside Rd 20764							
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 2/27/84		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lothian Anne Arundel Md.			
24. FUNERAL DIRECTOR NAME John O. Rausch Funeral Home					25a. DATE REC'D. BY REGISTRAR MAR 0 2 1984					
ADDRESS Cwings, Md.					25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03219

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Madeline</i> <i>McAllister</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Feb. 2, 1984</i>		2b. HOUR <i>8:30 am</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 15, 1920</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>63</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>A.A.Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Glen Burnie</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>North Arundel Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Eastern Venetian Products</i>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE 1 IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>A.A.Co.</i>	13c. CITY OR TOWN <i>Pasadena</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William</i> <i>Roberts</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cona</i> <i>Olney</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR RESERVE) <i>N/A</i>		17. INFORMANT ADDRESS <i>George Mc Allister same as 13 E</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M.</i> <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18B PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/82</i> , 19____, to <i>2/2/84</i> , 19____, that (I) (we) lost saw the deceased alive on <i>1/15/84</i> , 19____, and that in <i>MD</i> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>E. J. Zha</i>	DEGREE <i>MD.</i>	22c. DATE SIGNED <i>2/3/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>F. Kauer</i>	22e. ADDRESS <i>3708 Mt. Rd Pasadena</i>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>Feb. 3, 1984</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sec. Process Crem</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Catonville, Balto. Co. Md.</i>
24. FUNERAL DIRECTOR NAME ADDRESS <i>McCutty Funeral Home, Mt. & Tiedneck Rds. Pasadena, Md. 21122</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 3 1984</i>	
		25b. REGISTRAR'S SIGNATURE <i>John S. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SEIBER



THE UNIVERSITY OF CHICAGO

1953

1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) GEORGE C. McBride				2a DATE OF DEATH MONTH 2- DAY 2-19- YEAR 84				2b HOUR 1022 PM			
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH MONTH 2 DAY 20 YEAR 1896		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS 		8 IF UNDER 24 HRS. HOURS MIN 	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Den. Colo.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10 CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Conv. Ctr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Admin.		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. STATE MD		13b. COUNTY AA.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 27 Bay Drive 21403			
14 FATHER'S NAME FIRST John MIDDLE LAST McBride				15 MOTHER'S MAIDEN NAME FIRST Laura MIDDLE Frances LAST Kelly				16 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWI			
16 SOCIAL SECURITY NO. 585-05-5049				17 INFORMANT Mary M. Shanklin				17 ADDRESS same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4273 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Actual fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anemia, Osteoporosis											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (1) this hospital) attended the deceased from 19 78 to 2/19 19 84 , that (1) (we) lost saw the deceased alive on 2/19 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not) view the body after death.											
22a SIGNATURE George C. Samaras				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/19/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) George C. Samaras				22e. ADDRESS 205 Ridgely Ave Annapolis, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Feb 20, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD		23e. DATE REC'D BY REGISTRAR FEB 22 1984	
24 FUNERAL DIRECTOR NAME Taylor Funeral Chapel- Annapolis, MD				24 ADDRESS				25a. DATE REC'D BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Barbara E McDonald					2 - 16 - 84					10:20 AM
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female	white	MONTH DAY YEAR 8 11 21			62 YRS.		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.					
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY household			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Md.	13b. COUNTY A.A.Co.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1426 Rehling St. 21037					
14. FATHER'S NAME FIRST MIDDLE LAST Ralph G. Wilson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernice R. Eddins						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS William J. McDonald 1426 Rehling St. Edgewater, Md.						

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a)	Spiral Cord Metastasis	6 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) Breast Cancer	3 years
	DUE TO, OR AS A CONSEQUENCE OF (c)	

MEDICAL CERTIFICATION

PART 2 - OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 6			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Spinal Cord Tumor</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <u>May 17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Jack Kushner</u>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>2/17/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JACK Kushner</u>	22e. ADDRESS <u>20 Ridgely Ave Annapolis, Md.</u>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/21/84	23c. NAME OF CEMETERY OR CREMATORY Md Veterans Cemetery	23d. LOCATION CITY OR TOWN Crownsville, Md.	COUNTY A.A.	STATE
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home		ADDRESS 12 Ridgely Ave Ann. Md. 21411	25. DATE REC'D. BY REGISTRAR FEB 21 1984	25b. REGISTRAR'S SIGNATURE John Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 22 shows any injury, or other traumatic event, the medical examiner must be notified once.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03222

1. FOR
STATE
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) WILLIAM H MCGEE SR		2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 8, 1984		2b. HOUR 555 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 22, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE New York		13b. COUNTY Tioga	13c. CITY OR TOWN Waverly	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Warren		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Beatty		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2	17. INFORMANT ADDRESS Md. 21054 Warren McGee, 2230 Dairy Farm Rd., Gambrills	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1850

IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) METASTATIC CARCINOMA, PROSTATE

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

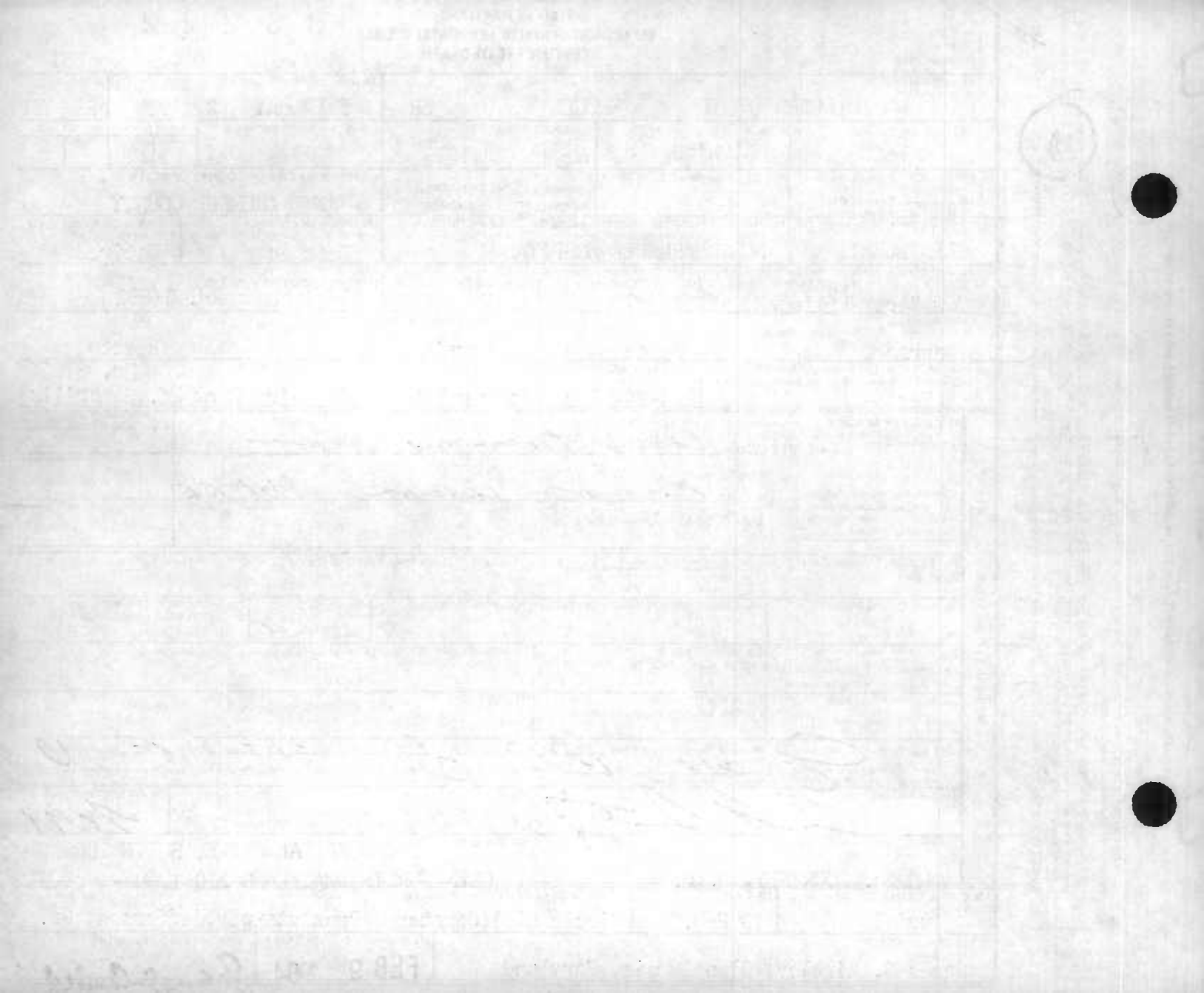
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/3, 1984, to 2/8, 1984, that (I) (we) last saw the deceased alive on 2/8, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE L. A. Courtney M.D.		DEGREE		22c. DATE SIGNED 2/8/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. A. COURTNEY, M.D.		22e. ADDRESS 200 HOSPITAL DRIVE, SUITE 206 GLEN BURNIE, MARYLAND 21061		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 13 Feb. 84	23c. NAME OF CEMETERY OR CREMATORY Circle Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Punxsutawney, Jefferson, Pa.
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 9 1984	
		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

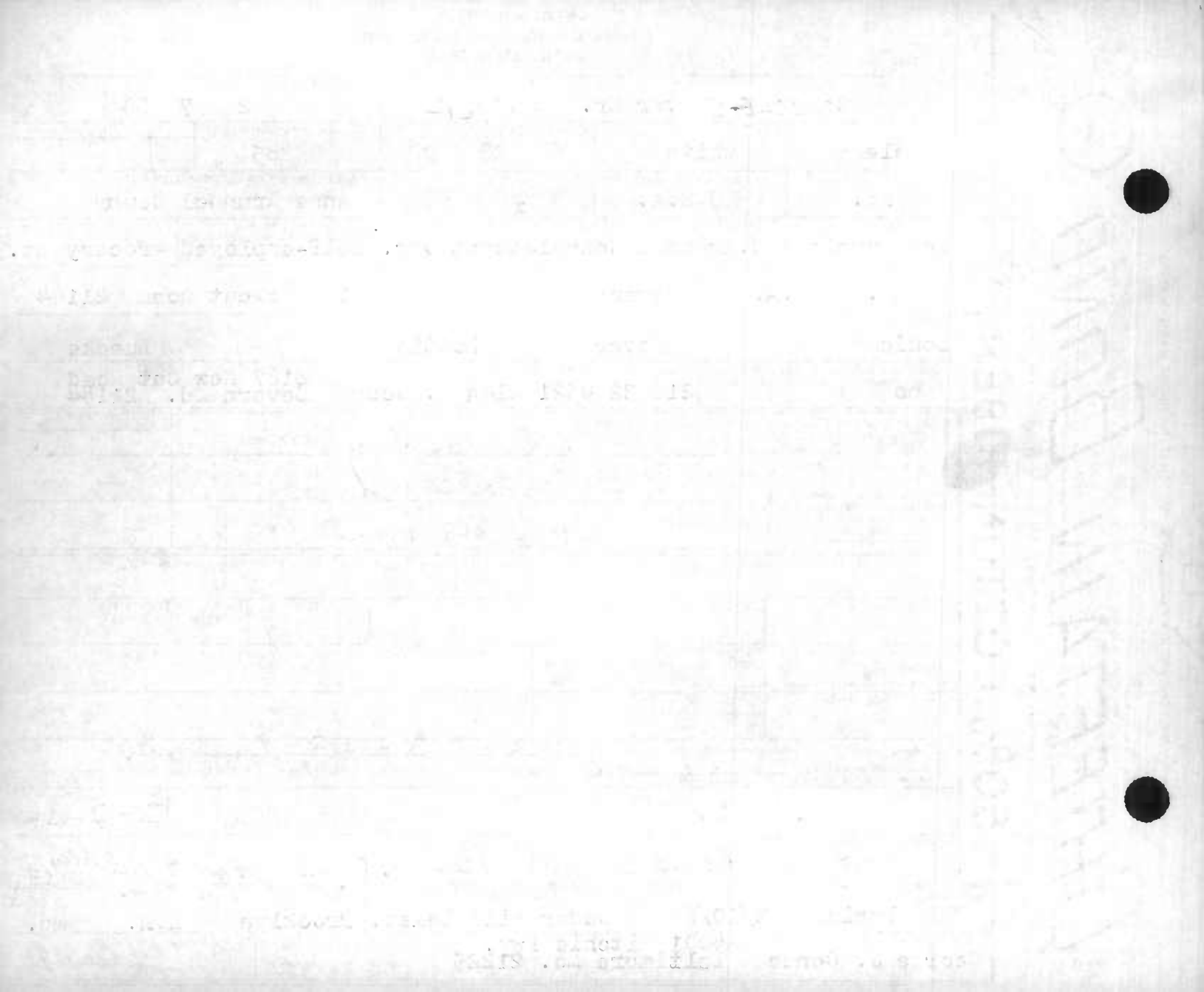
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03223			
1. FOR STATE REGISTRAR							
I. DECEASED NAME (TYPE OR PRINT) George H. Meyer Sr.				2a. DATE OF DEATH MONTH DAY YEAR 2 7 84		2b. HOUR M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 6 28 98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF KNOWN SUCH FACILITY, GIVE STREET ADDRESS) N. Arundel Convalescent Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) self-employed		12b. KIND OF BUSINESS OR INDUSTRY grocery st.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. CITY OR TOWN Severn		13c. STREET ADDRESS 8189 Newcut Road 21144	
FATHER'S NAME FIRST MIDDLE LAST Louis Meyer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Luedke			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 32 9521		17. INFORMANT ADDRESS 8187 New Cut Road Severn Md. 21144			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1850 - Cardiorespiratory Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic Coma.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Melanotic Prostate Cancer.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-24</u> 19 <u>84</u> , to <u>2-7</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>1-24</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2-7-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDER MD				22e. ADDRESS 7445A FURNACE BRANCH Rd Glen B.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/10/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemeter.		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.	
24. FUNERAL DIRECTOR NAME George J. Gonce				4001 Ritchie Hwy. Baltimore Md. 21225		25a. DATE REC'D. BY REGISTRAR FEB 8 1984	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP



ORIGINAL FILED IN

RECEIVED

DATE: 11/10/11 BY: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				03224				EST	
1. FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) ANDREW MILES				2a. DATE OF DEATH MONTH FEBRUARY DAY 07 , YEAR 1984				2b. HOUR 510 AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH 7 DAY 25 YEAR 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN) Roberson, N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY Pet.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE md 13c. COUNTY 				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 1411 N. Fulton Ave 21217			
14. FATHER'S NAME FIRST Jacob MIDDLE LAST Miles				15. MOTHER'S MAIDEN NAME FIRST Annie MIDDLE LAST Miles					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-05-1963		17. INFORMANT ADDRESS Balts. md Violet Wms - 1411 N. Fulton Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 5070 DUE TO, OR AS A CONSEQUENCE OF: (b) PULMONARY EMBOLISM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ASPIRATION PNEUMONIA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS.	
								12 HRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). SEPTICEMIA 2° INFECTED AMPUTATION STUMP									
19a. DATE OF OPERATION 2-3-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - INABILITY TO THRIVE				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10-31-83 , 19 83 , to 2-7 , 19 84 , that (I) (we) lost saw the deceased alive on 2-7 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE ADOLFO G. TORRES, M.D.				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-7-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 7845 OAKWOOD ROAD SUITE 201 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 2/11/84		23c. NAME OF CEMETERY OR CREMATORY ST Rest		23d. LOCATION CITY OR TOWN COUNTY STATE Hanover AA md			
24. FUNERAL DIRECTOR NAME Funell B. Oden ADDRESS Balts. md				25a. DATE REC'D. BY REGISTRAR FEB 21 1984		25b. REGISTRAR'S SIGNATURE Antonia-Rodriguez			

BP _____

Todd Miles Brown

[illegible]

2/11/81 27 feet

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMM - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. FOR STATE REGISTRAR						03225	
1. DECEASED NAME (TYPE OR PRINT) Rosine S. Miller						2a. DATE OF DEATH MONTH DAY YEAR 2-3-84	
3 SEX FEMALE						2b. HOUR 1:10 PM	
4 RACE WHITE						6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR 10-18-08						IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA						IF UNDER 24 HRS HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY? UNITED STATES						9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
10. CITY OR TOWN OF DEATH ANNAPOLIS						12b. KIND OF BUSINESS OR INDUSTRY HOME	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSP.							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ARNOLD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JEFFERSON						13e. STREET ADDRESS / ZIP CODE 216 DANCASTER RD. 21012	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LYDIA JOHNSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO						16b. SOCIAL SECURITY NO. 261-03-4242	
17. INFORMANT ADDRESS PATRICIA STEINER (SAME AS 13)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4960 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULM. DS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) fracture left hip @ 1 month previous							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/30/84 , 19____, to 2/3/84 , 19____, that (I) (we) lost saw the deceased alive on 2/2/84 , 19____, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRANCO FUNERAL HOME		22e. ADDRESS 501 RITCHIE HWY SEVENTH FLOOR, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE EUSTIS LAKE FLA.	
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME		ADDRESS 501 RITCHIE HWY SEVENTH FLOOR, MD.		DATE REC'D. BY REGISTRAR FEB 6 1984		REGISTRAR'S SIGNATURE [Signature]	



78000101 Jones Creek

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 3 2 2 6

EST

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA Rebecca MUELLER			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 9, 1984			2b. HOUR 340 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Secretary		12b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13e. STREET ADDRESS / ZIP CODE 409 S. Collington Ave., 21231			
14. FATHER'S NAME FIRST MIDDLE LAST August Mueller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Burnmeister					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 213-01-0077		17. INFORMANT ADDRESS Mrs. Edna Bachmann 5212 Ballman Ave., Balto., Md. 21225			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1579

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 hrs

4 hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

MEDICAL CERTIFICATION

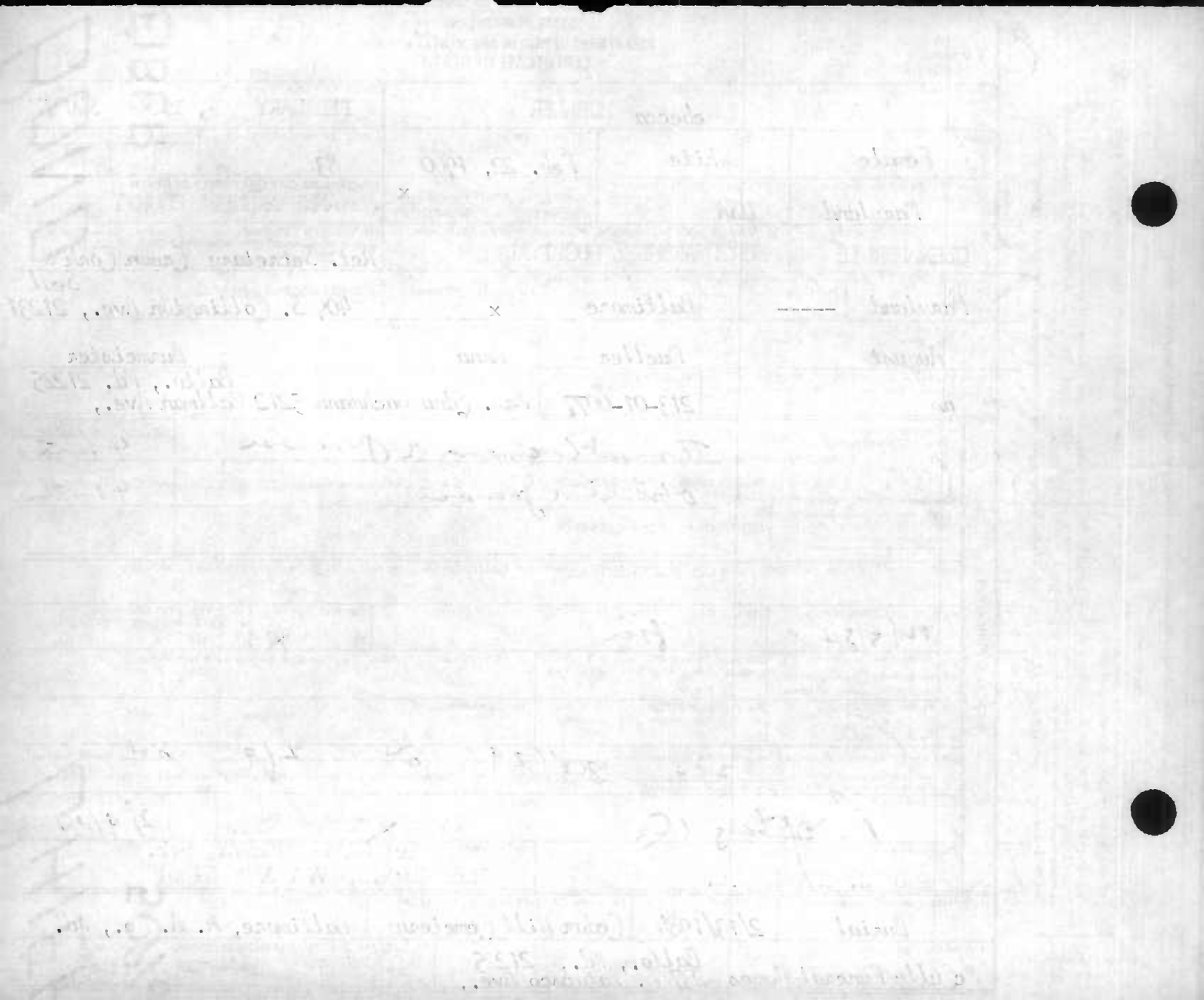
19a. DATE OF OPERATION 2/5/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED fr		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/29 , 19 84 , to 2/9 , 19 84 , that (I) (we) lost saw the deceased alive on 2/9 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul J. Chang		DEGREE		22c. DATE SIGNED 2/9/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL J. CHANG, M.D.		22e. ADDRESS 801 CHAIN HIGHWAY, S.E. GLEN BURNIE, MARYLAND 21061					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/13/1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, A. A. Co., Md.	
24. FUNERAL DIRECTOR NAME McCully Funeral Homes				ADDRESS Balto., Md., 21225 237 E. Patapsco Ave.,		25a. DATE REC'D. BY REGISTRAR	
				25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William (NMN) Mueller, Sr			2a. DATE OF DEATH MONTH DAY YEAR Feb 13 1984			2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 14, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 500 Defense Highway		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Maintenance		12b. KIND OF BUSINESS OR INDUSTRY H.A. Co	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Mueller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Rosenhauer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-22-1300	
17. INFORMANT ADDRESS Same as #13							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4254
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Cardio megalay.

DUE TO, OR AS A CONSEQUENCE OF

(c) Cardiomyopathy

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Ventricular tachycardia, complete heart block & pump failure.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/18/84 to 2/13/84, that (I) (we) lost saw the deceased alive on 1/18/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Key (Perron)		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/13/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Samaras		22e. ADDRESS 205 Ridgely Ave, Annapolis, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 15, 1984		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD		25. DATE RECEIVED BY REGISTRAR FEB 15 1984		26. SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 was any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Howard Vincent Murphy			2a. DATE OF DEATH MONTH DAY YEAR 2-19-84		2b. HOUR 10:45 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-05-03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO MD		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR A LOSS OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Civil Service		
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Gambrills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Joseph Murphy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Tyler		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE DATE(S)) Yes WWII				
17. INFORMANT Wilbur F. Murphy		ADDRESS 3476 Savannah Dr. Davidsonville MD 21035		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Leukemia 2080 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2/10 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 2/10 84		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2/19 84		21g. I certify that (I) (this hospital) attended the deceased from 2/19 84 to 2/19 84 , that (II) (we) last saw the deceased alive on above, (II) (we) did (did not) view the body after death.		
22a. SIGNATURE Euse W. Cole		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/20/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E COLE		22e. ADDRESS 57 FRANKLIN ANNAP MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 23 1984		23c. NAME OF CEMETERY OR CREMATORY MD, Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville AA MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis MD		ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, there was any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten notes at the top of the page, including the date "2nd Nov 1914" and various illegible entries.

Handwritten notes in the middle section of the page, continuing the entries.

Handwritten notes in the lower middle section of the page.

Handwritten notes in the lower section of the page.

Handwritten notes at the bottom of the page, including the date "2nd Nov 1914" and various illegible entries.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James A. MURRAY Sr.			2a. DATE OF DEATH MONTH DAY YEAR 2 25 84			2b. HOUR M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 7/13/1922		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Harwood Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) engineer		12b. KIND OF BUSINESS OR INDUSTRY A.A. Co. Gov	
13a. STATE Md.			13b. COUNTY A.A. Co.		13c. CITY OR TOWN Harwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William T. Murray Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edmonia H. Colhoun			13e. STREET ADDRESS 1141 Cumberstone Rd. 20776			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Roberta E. Murray same as 13e.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2028 IMMEDIATE CAUSE (a) LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1982, 19, to 2/25/84, 19, that (I) (we) lost saw the deceased alive on 2/25/84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stanley Watkins for Dr. E. Cole					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/27/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY WATKINS					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/26/84		23c. NAME OF CEMETERY OR CREMATORY Christ Episcopal		23d. LOCATION CITY OR TOWN COUNTY STATE West River, Md. A.A. Co.		
24. FUNERAL DIRECTOR NAME hardesty Funeral Home					ADDRESS 12 Ridgely Ave Ann. Md. 21401		25a. DATE REC'D. BY REGISTRAR FEB 28 1984		
					25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

MEDICAL CERTIFICATION

2

PALESTINE

20% COUNCIL



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

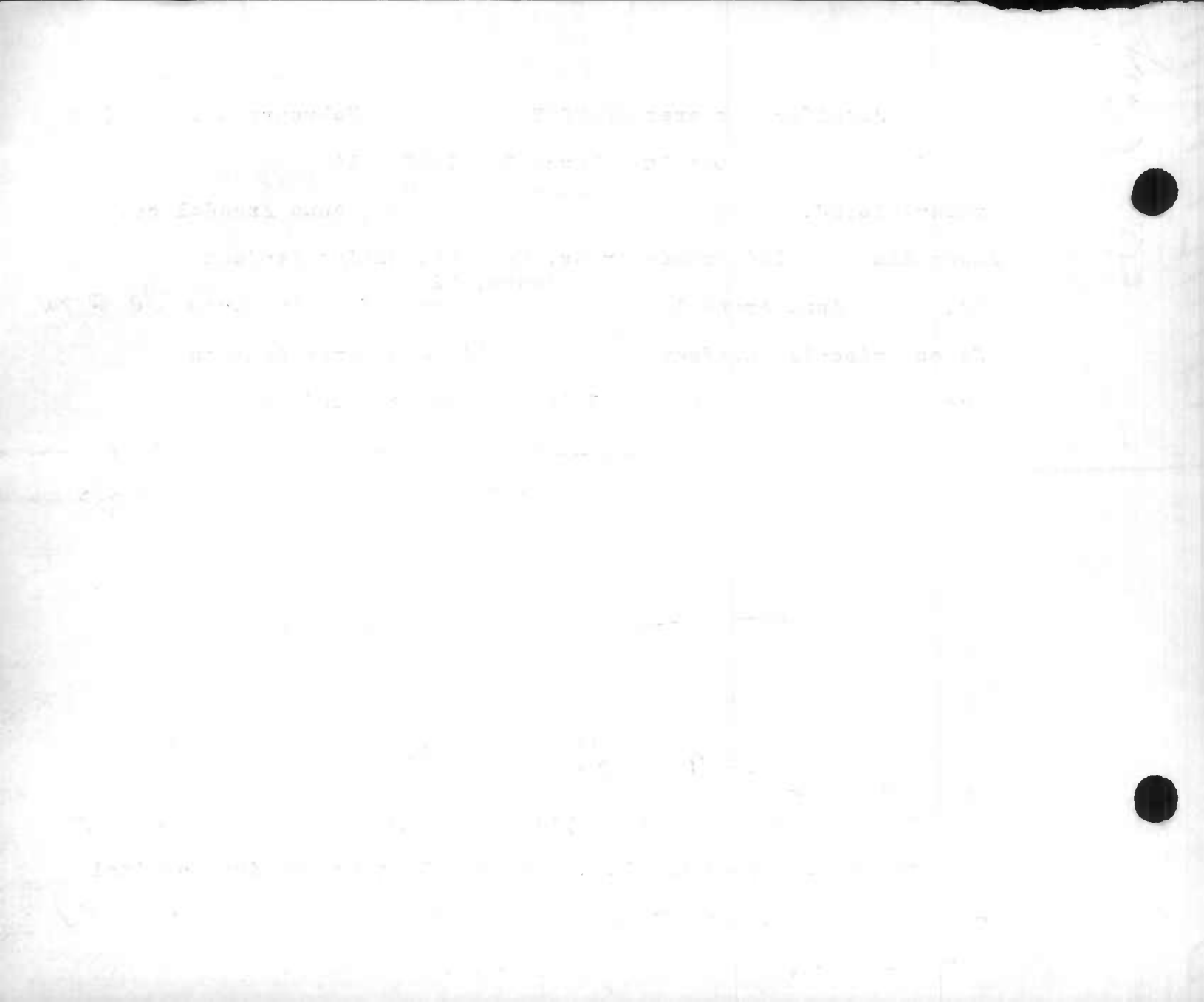
1. DECEASED NAME (TYPE OR PRINT) Jennifer Margaret NEAFSEY			2a. DATE OF DEATH MONTH DAY YEAR February 25, 84			2b. HOUR 8 pm M				
3. SEX f		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR March 20, 1969		6. AGE (IN YEARS LAST BIRTHDAY) 14 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 14		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greenville, SC.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel co. MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 704 Broadmoor Dr. Cape St. Claire Student				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. STREET ADDRESS / ZIP CODE 704 Broadmoor Dr. 21061			
14. FATHER'S NAME FIRST MIDDLE LAST James Driscoll Neafsey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Anne Sheahan						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219 96 7545		17. INFORMANT ADDRESS Elizabeth Neafsey						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary metastasis DUE TO, OR AS A CONSEQUENCE OF (b) Osteosarcoma DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1629								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr 3 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/1 , 19 80 , to 2/25 , 19 84 , that (I) (we) last saw the deceased alive on 2/19 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Brigid G. Leventhal					DEGREE MD			22c. DATE SIGNED 2/26/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brigid G. Leventhal, M.D.					22e. ADDRESS CMSC 801 Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-29-84		23c. NAME OF CEMETERY OR CREMATORY Lakemont Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE DAVIDSONVILLE A.A. MD				
24. FUNERAL DIRECTOR NAME T. A. HARDESTY					ADDRESS Annapolis Md 21031		25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

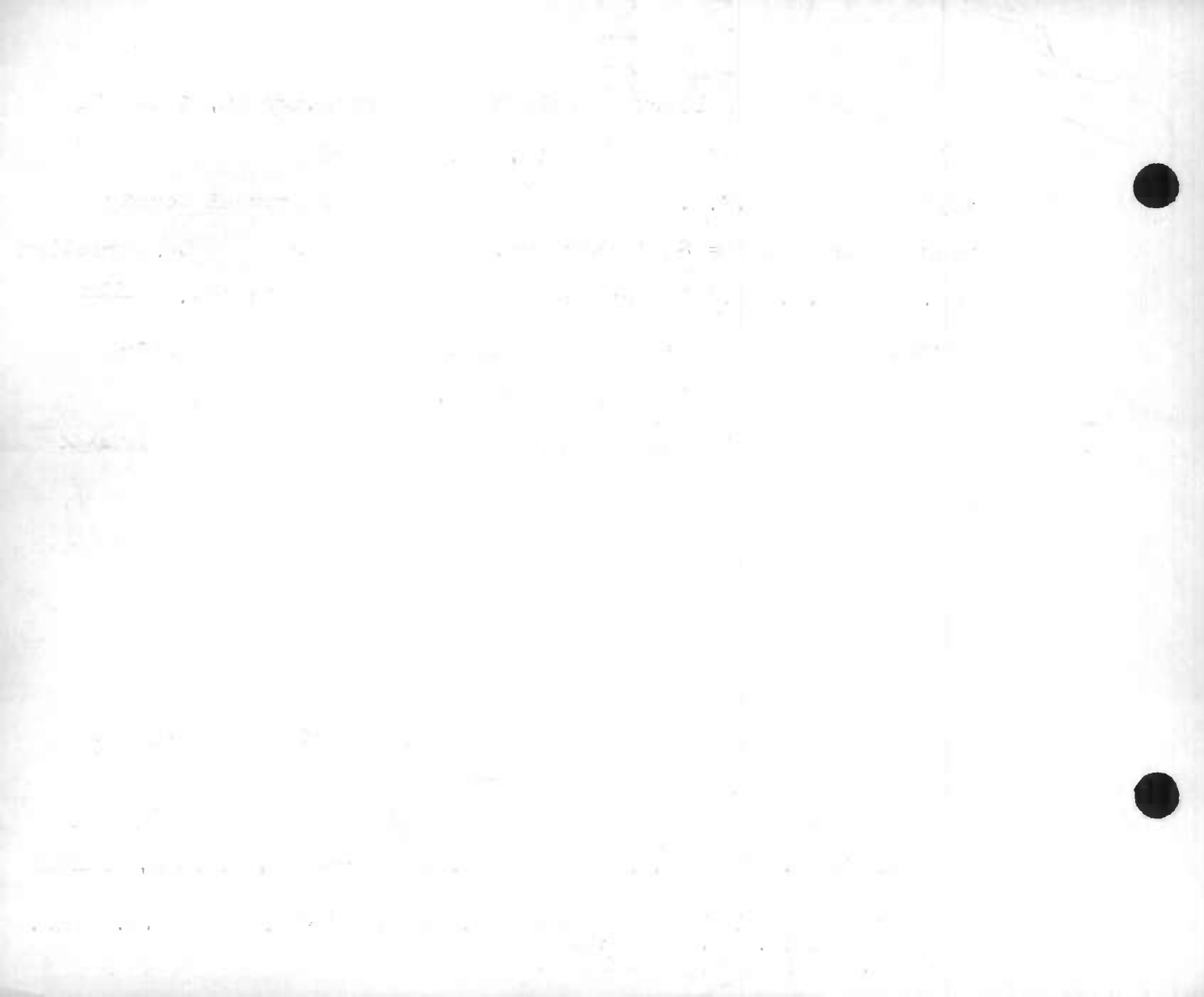
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Edwin Albert Nelson					February 26, 1984				7A M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
Male	White	Nov 16, 1915		68	MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.			Anne Arundel County MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Riviera Beach	Home = 8431 Main Ave.		Welder		Construction				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
Md.		A.A. Co.	Riviera Bch	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	8431 Main Ave. 21122				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Frank Nelson		Alice Wroten							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		212 09 9600		Erma G. Nelson same as 13 e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lung cancer</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/12</u> 19 <u>84</u> , to <u>2/26</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/12</u> 19 <u>84</u> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Lorraine M. Dailey M.D.</u>						<u>2/28/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Lorraine M. Dailey M.D.		8667 Fort Smallwood Rd, Pasadena, Md 21122							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		3/1/84		Cedar Hill Cemetery		Brooklyn A.A. Arundel Md.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George J. Gonce		4001 Ritchie Hgwy		MAR 1 1984					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										EST	
FOR 1. STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZA J NOEL						2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 04, 1984			2b. HOUR PM 0947 PM		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 8 03		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MINS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) proprietor		12b. KIND OF BUSINESS OR INDUSTRY Restaurant			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.						13b. COUNTY A.A.		13c. CITY OR TOWN Brooklyn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Rosser Schools						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Martin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 214 30 6205A		17. INFORMANT 48 West Earlehigh Hgts Rd. Shirley Daniels Severna Park Md. 21146					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCUT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal Failure + Anemia + Sepsis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M.			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/7/84</u> to <u>2/4/84</u> that (I) (we) last saw the deceased alive on <u>2/7/84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>2/8/84</u>		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ANASTASIO E. SUBON			22g. ADDRESS 4730 MOUNTAIN ROAD PASADENA, MARYLAND 21122								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 2/7/84			23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.		
24. FUNERAL DIRECTOR NAME George J. Gonce			4001 Ritchie Hwy. Baltimore Md. 21225			25a. DATE REC'D. BY REGISTRAR FEB 8 1984			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



Handwritten text and faint printed text at the top of the page, including a date "1914" and various illegible words.

Large handwritten text in the center of the page, appearing to be a signature or a long note, written in cursive.

Handwritten text and faint printed text at the bottom of the page, including a date "1914" and various illegible words.

Vertical text on the right side of the page, possibly a page number or a reference code.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WARREN G. NORRIS			2a. DATE OF DEATH MONTH 2 DAY 4 YEAR 84		2b. HOUR 935 M	
3 SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 5 DAY 26 YEAR 20		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.		
10. CITY OR TOWN OF DEATH ANNAPO LIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION Superintendent		
13a. STATE Md			13b. CITY OR TOWN HARWOOD		13c. STREET ADDRESS / ZIP CODE 319 S River Club House Rd. 20776	
14. FATHER'S NAME FIRST Egbert MIDDLE Cadden LAST Norris			15. MOTHER'S MAIDEN NAME FIRST Grace MIDDLE LAST Erdman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF KNOWN, GIVE YEAR AND MONTH DATES) 218-03-2380		17 INFORMANT Elsie Katherine Norris ADDRESS 319 S Club House Rd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca Luvy 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2/83 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on 2/4/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE Stanley P. Watkins DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/5/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY P. WATKINS		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 8, 1984		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		
23d. LOCATION CITY OR TOWN Baltimore COUNTY Md. STATE		24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Maryland				
25a. DATE REC'D. BY REGISTRAR FEB 7 1984		25b. REGISTRAR'S SIGNATURE John J. Gwinn				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary E. Noyes					2a. DATE OF DEATH MONTH DAY YEAR Feb. 6, 1984			2b. HOUR 6:30 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 20, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Conv. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 410 Hideaway Loop 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Gocking				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Desch					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-05-1487		17. INFORMANT ADDRESS Eugene Noyes 202 Ferndale Ave. 21061					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>4960</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>LEFT LOWER LOBE PNEUMONIA</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 31</u> , 19 <u>84</u> , to <u>FEB 6</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>JAN 31</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Barry R. Nathanson</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7 FEB. 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry R. Nathanson M.D.				22e. ADDRESS 51 Franklin St. Annapolis					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6 Feb. 84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley Glen Burnie MD.				25a. DATE REC'D. BY REGISTRAR FEB 8 1984		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>			

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POST OFFICE

FEB 8 1904

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				EST	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOHN WHITTINGTON OLER			2a. DATE OF DEATH MONTH FEBRUARY DAY 8 , 1984 2b. HOUR 145 A M		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 08 DAY 03 YEAR 04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHEET METAL WORKER		12b. KIND OF BUSINESS OR INDUSTRY UNION 100
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN RELAY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1600 LINDEN LANE, 21227		15. MOTHER'S MAIDEN NAME FIRST ANNA MIDDLE ARNDT LAST ARNDT			
14. FATHER'S NAME FIRST JOHN MIDDLE W. LAST OLER		15. MOTHER'S MAIDEN NAME FIRST ANNA MIDDLE ARNDT LAST ARNDT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-05-4704		17. INFORMANT WILLIAM PRICE ADDRESS GLEN BURNIE, MD. 702 MARBORO ROAD 21061	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute and Chronic Renal Failure.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-7-84 to 2-8-84 , that (I) (we) lost saw the deceased alive on 2-7-84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 2-8-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK I. STERN, M.D., P.A.		22e. ADDRESS 300 HOSPITAL DRIVE, SUITE 135 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 02-11-84		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK. ELKCRIDGE HOWARD MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR FEB 10 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

EST

FEBRUARY 6, 1981

WELLINGTON OLEA

JOHN

ANN ARUNDEL COUNTY

NORTH ARUNDEL HOSPITAL

OLEA BURNE

300 HOSPITAL DRIVE, SUITE 100
OLEA BURNE, MARYLAND 20681

JOHN I. STERN, M.D., P.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4557 b7c

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

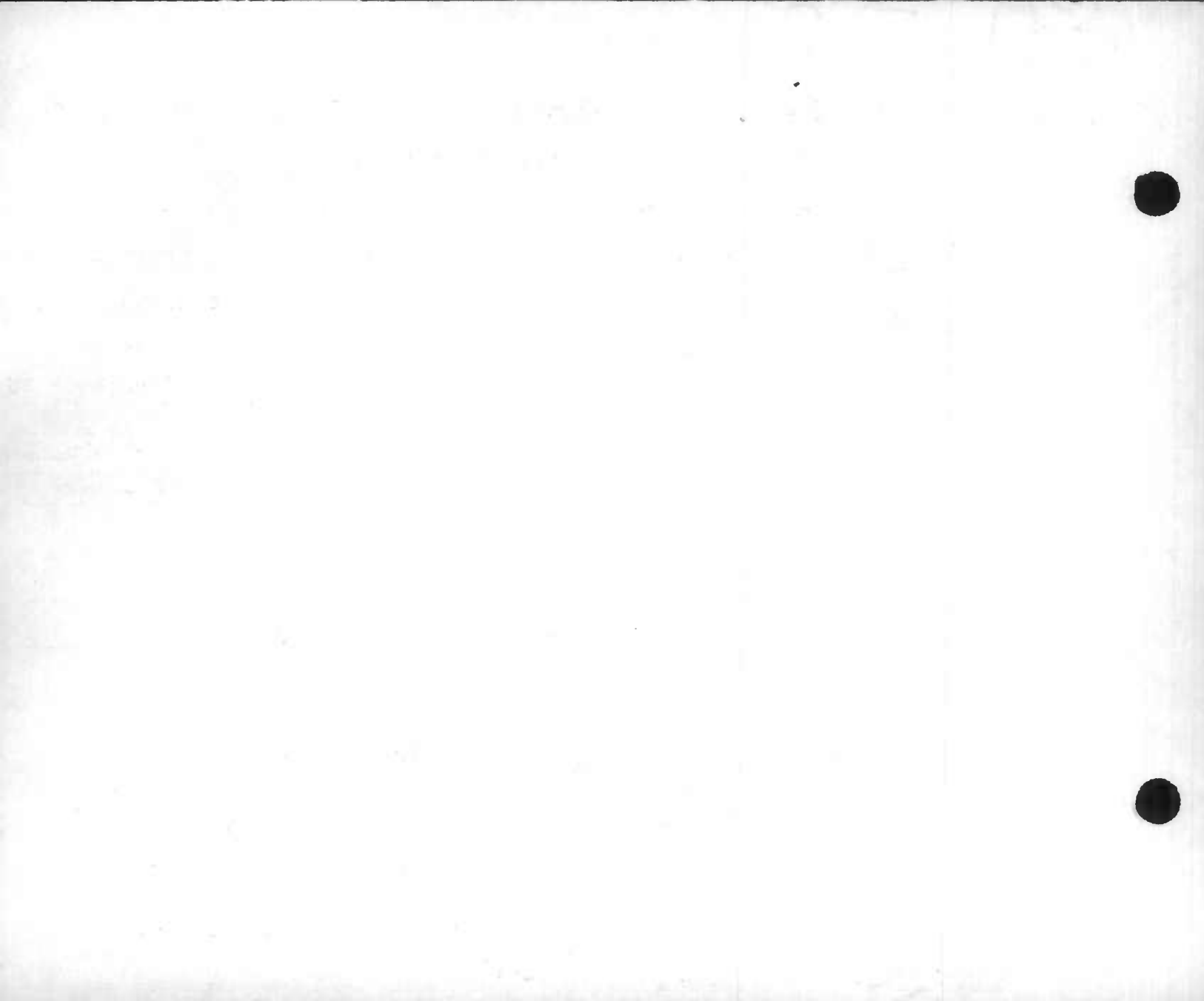
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Nellie Patten</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2-13-84</i>			2b. HOUR <i>19:07</i> M.				
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 15, 1895</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Fleetwood England</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co</i> MD.				
10. CITY OR TOWN OF DEATH <i>Annapolis</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Anne Arundel General Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>retail sales</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>			13b. COUNTY <i>A.A. Co.</i>		13c. CITY OR TOWN <i>Deale</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE <i>5827 Deale Churchton Rd.</i>			13f. ZIP CODE <i>20756</i>							
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Leadbetter</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Wilson</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>			16b. SOCIAL SECURITY NO. <i>579-22-2462</i>		17. INFORMANT <i>Doris Gonzales</i>				ADDRESS <i>5827 Deale Churchton Rd. Deale, Md. 20756</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULM. EMBOLUS or MYOCARDIAL INFARCT</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>		
4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i>								2 Wks		
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <i>JAN 19 84</i> to <i>2/13 19 84</i> , that (I) (we) last saw the deceased alive on <i>2/12 19 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>Harvey J. Steinfeld</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>2/13/84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HARVEY J STEINFELD</i>			22e. ADDRESS <i>SHADYSIDE MD 20764</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/16/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodfield Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Galesville, Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Hardesty Funeral Home</i>			ADDRESS <i>Ann. Md. 21401</i>			25a. DATE REC'D. BY REGISTRAR <i>FEB 15 1984</i>		25b. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>		

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FREDERICK I. PATTERSON			2a. DATE OF DEATH MONTH 2 DAY 19 YEAR 84			2b. HOUR 1^{PM}			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 7 DAY 4 YEAR 98		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALVERT CO MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH A.A. CO MD.			
10. CITY OR TOWN OF DEATH CLON BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH BRUNNOL HOSP.				12a. USUAL OCCUPATION (NAME OF WORK FOR MOST OF WORKING LIFE) PERIDONTSNOMAN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN JEFFERSON PK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 309 RICHMOND HWY 21146	
14. FATHER'S NAME FIRST JOHN MIDDLE ANDREW LAST PATTERSON				15. MOTHER'S MAIDEN NAME FIRST ANNIE MIDDLE M LAST HOCKS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-01-2930		17. INFORMANT ADDRESS GERALDINE GREENE 309 RICHMOND HWY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA LUNG (cancer) 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov 19 83 to Nov 19 83 , and that in my (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/24/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kingston		22e. ADDRESS 848 Hamilton Ave							
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial		23b. DATE 2/25/84		23c. NAME OF CEMETERY OR CREMATORY MT CALVARY		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD 21225			
24. FUNERAL DIRECTOR NAME The Anshel P. Shapiro				ADDRESS 636 91st St		25a. DATE REC'D. BY REGISTRAR EB 23 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) LAURA.		FIRST		MIDDLE	LAST		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 16, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNAPOLIS CONVALSCENT CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOUSEHOLD	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST PARD BATES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELINORA POWELL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 570-22-9751	
17. INFORMANT ADDRESS WINIFRED WILSON 13 e.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E. W. COLE		DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. W. COLE		22e. ADDRESS 51 FRANKLIN ST ANNAPOLIS Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/4/84		23c. NAME OF CEMETERY OR CREMATORY LEHIGH ACRES MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE LEHIGH ACRES FLA.	
24. FUNERAL DIRECTOR NAME ADDRESS HARDESTY FUNERAL HOME ANNAPOLIS, MD		25a. DATE REC'D. BY REGISTRAR FEB 2 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				26. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN K. Penn				8 Feb 84 4:40 P			
3. SEX M		4. RACE Cav		5. DATE OF BIRTH MONTH DAY YEAR 11/21/24		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Ft. Meade		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbraugh		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret		12b. KIND OF BUSINESS OR INDUSTRY US Army	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. CITY OR TOWN Anne Arundel		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 16 Thomas Ave 21225	
14. FATHER'S NAME FIRST MIDDLE LAST 7 WILLIAM NORMAN PENN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST 7 W OLGA PENN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 213-20-0337		17. INFORMANT ADDRESS MRS RUTH PENN 2806 Manoff Rd Bel Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 minutes
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (his hospital) attended the deceased from 31 Jan 19 84 , to 8 Feb 19 84 , that (1) (he) last saw the deceased alive on 8 Feb 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.							
22b. SIGNATURE DM				DEGREE		22c. DATE SIGNED 8 Feb 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas Cummings				22e. ADDRESS KACH			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/13/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Ambrose, Inc. 1328 Sulphur Spring Rd.				25a. DATE REC'D. BY REGISTRAR FEB 10 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		EST	
1. DECEASED NAME (TYPE OR PRINT) CHARLES M. PLUMER					2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 11, 1984				2b. HOUR 11:25 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 31, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Federal Employee			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.				
13a. STATE Maryland					13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1868 Cedar Rd./Pasadena 21122		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph - Plumer					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa - Raab								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II		17. INFORMANT ADDRESS Ann Marie Plumer / 1868 Cedar Rd. (21122)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Obliterans DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Arteriosclerotic heart disease													
19a. DATE OF OPERATION 2/7/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right carotid stenosis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from 2/6 , 19 84 , to 2/11 , 19 84 , that (1) (we) last saw the deceased alive on 2/11 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.													
22b. SIGNATURE Arthur L. Gudwin					22c. DATE SIGNED 2/12/84			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR ARTHUR L. GUDWIN					22f. ADDRESS 7300 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 14, 84		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, - , Maryland					
24. FUNERAL DIRECTOR NAME Lilly & Zeiler Inc. 700 S. Conkling St./21224					25. DATE REC'D. BY REGISTRAR FEB 14 1984		25. REGISTRAR'S SIGNATURE J. Davidson-Randall						

BP

Name	Address	City	State	Occupation	Age	Sex	Marital Status	Education	Religion	Political Party	Other
Maryland	United States										
Maryland	Anne Arundel										
Joseph	Pharm										
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 Baltimore, Md. - Maryland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03241

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Pociluyko, Nicholas D.			2a. DATE OF DEATH MONTH Feb DAY 4 YEAR '84			2b. HOUR 0730	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH Nov DAY 11 YEAR 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Ft MEADE, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Community Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED - Army		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD COUNTY BALTIMORE CITY OR TOWN BALTIMORE		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 5837 OAKLAND RD		13d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21227	
14. FATHER'S NAME FIRST Peter Pociluyko MIDDLE LAST 				15. MOTHER'S MAIDEN NAME FIRST Irene MIDDLE LAST 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 176-32-5124		17. INFORMANT ADDRESS Mrs. Delphine R. Pociluyko 5837 Oakland Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF PROSTATE WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) 							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: ASCITES							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Vincent P. Ang				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4 Feb 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VINCENT P ANG				22e. ADDRESS USAMEDPAC, Ft Meade Md 20755			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/7/84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION CITY OR TOWN Dorsey COUNTY Howard STATE Maryland	
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home ADDRESS 1328 Sulphur Spring Rd.				25a. DATE REC'D. BY REGISTRAR FEB 6 1984		25b. REGISTRAR'S SIGNATURE Sam S. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Signed may be retained by the hospital or attending physician.

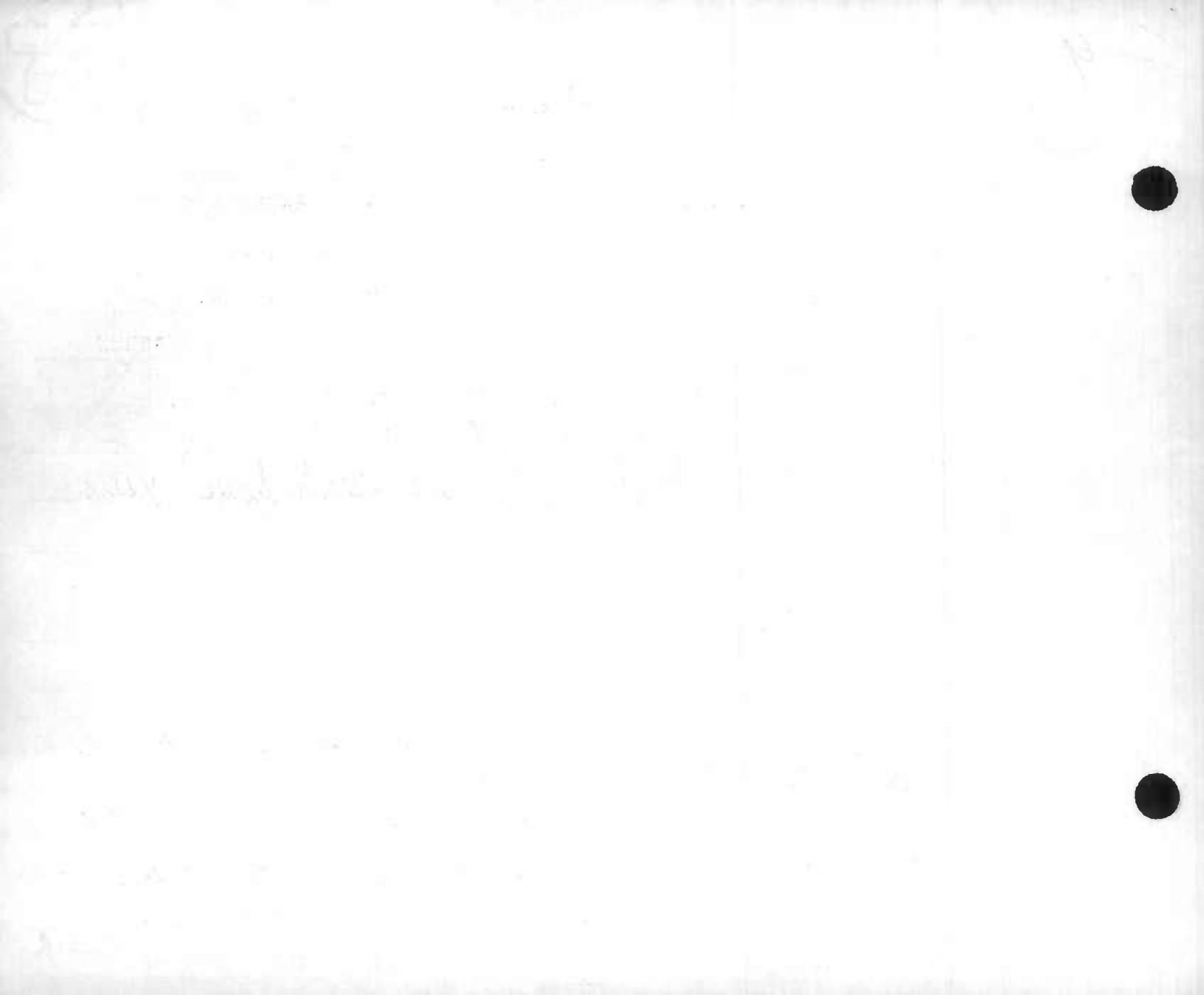
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03242

FOR 1- STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lonnie E. Polson</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>2-6-84</i>	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 11 1914	
7a. BIRTHPLACE (STATE OR FOREIGN) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. GENERAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM POLSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HATTIE WARREN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRICK LAYER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-01-6404		17. INFORMANT CHARLOTTE E. POLSON 13 e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Arrest</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Arteriosclerotic Cardio-Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>Years.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from <i>Feb 3</i> 19 <i>84</i> , to <i>Feb 6</i> 19 <i>84</i> , that (1) (we) last saw the deceased alive on <i>Feb 6</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Barry R. Nathanson MD</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>2/7/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON				22e. ADDRESS 51 FRANKLIN ST. ANNAPOLIS, MD 21401	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/9/84		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	
24. FUNERAL DIRECTOR NAME HARDESTY FUNERAL HOME ANNAPOLIS, MD		23d. LOCATION CITY OR TOWN SUITLAND		23e. COUNTY P.G.	
23f. STATE MD		25a. DATE REC'D. BY REGISTRAR FEB 8 - 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Conish</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as on page 3.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03243

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Orlando (NMN) Ridout III</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>Feb. 18, 1984</u>				2b. HOUR <u>12:30</u> P.M.	
3 SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>4 4 95</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>88</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Anne Arundel Co., MD.</u>			
10. CITY OR TOWN OF DEATH <u>Annapolis</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Anne Arundel General Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Farmer</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>MD</u>		13b. COUNTY <u>AA</u>		13c. CITY OR TOWN <u>Annapolis</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>1811 Whitehall Road 21401</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Orlando Ridout, II</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Maria Duvall</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR AND DATES) <u>Yes WWII</u>				16b. SOCIAL SECURITY NO. <u>218-36-1208</u>		17. INFORMANT ADDRESS <u>Mary McKinsey Ridout - #13 Same as</u>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypoxalemia Shock 2° to</u> <u>4422</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ruptured iliac artery</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hr</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 18, 1984</u> , to <u>Feb. 18, 1984</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>Feb. 18, 1984</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did (did not) view the body after death.									
22b. SIGNATURE <u>Gary M. Richardson, M.D.</u>						DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>2-18-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GARY M. RICHARDSON, MD.</u>						22e. ADDRESS <u>104 Forbes Street Annapolis, MD 21401</u>			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <u>Burial</u>				23b. DATE <u>Feb 22, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Whitehall</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Annapolis AA MD</u>	
24. FUNERAL DIRECTOR NAME <u>Taylor Funeral Chapel - Annapolis, MD</u>						25a. DATE REC'D. BY REGISTRAR <u>FEB 22 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.				EST			
1. DECEASED NAME (TYPE OR PRINT) Milton Hollingsworth RUSSELL				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 14, 1984				2b. HOUR 10:03 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 6 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
11. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed			
13a. STATE Maryland				13b. COUNTY A.A.		13c. CITY OR TOWN GlenBurnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7885 Gordon Ct. Apt. 578 21061	
14. FATHER'S NAME FIRST MIDDLE LAST William V. Russell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Elizabeth Hollingsworth							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. W.W. II 226.18.6167		17. INFORMANT (SON) David Russell-426 Cherry Lane 21660				ADDRESS Ridgely, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> 4850 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute and chronic respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchopneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>2-16</u> 19 <u>83</u> , to <u>2-14</u> 19 <u>83</u> , that (1) (we) lost saw the deceased alive on <u>2-14</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward N. Sherman				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-14-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD N. SHERMAN, M.D.				22e. ADDRESS 7422 Baltimore-Annapolis Blvd. Glen Burnie, Maryland 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb 17 1984		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Prk		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.			
24. FUNERAL DIRECTOR NAME Singleton Funeral Home				ADDRESS Glen Burnie, Md		25a. DATE REC'D. BY REGISTRAR FEB 16 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

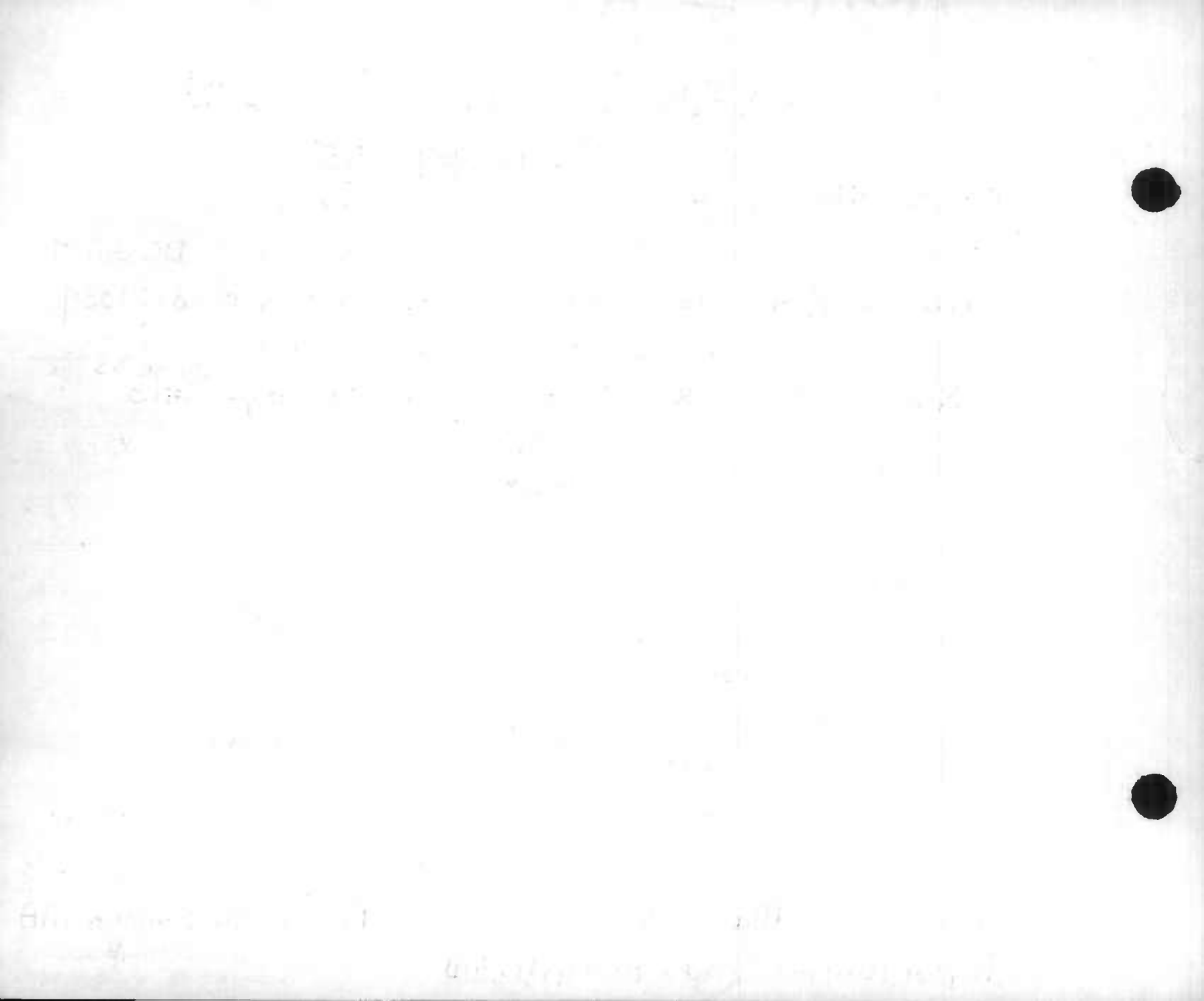
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JESSIE Natalie RUTKOVSKY			2a. DATE OF DEATH MONTH 29 YEAR 84 10:39am	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR Feb. 10, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7b. BIRTHPLACE (STATE OR FOREIGN) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH AA Co. MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A.G.H.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY DC Gov't.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 211 Holly Road - 21037	
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 016-07-0039A		17. INFORMANT Serge N. Rutkovsky - same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 2768 DUE TO, OR AS A CONSEQUENCE OF (b) Possible Hypokalemia DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertension				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:50 P.M. 2 27 1984	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) 134 Owensville Rd, West River Md.	21f. LOCATION CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9 19 82 to 2/27/84 19 84, that (I) (we) last saw the deceased alive on 2/27 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Sheila Rhodes	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHEILA RHODES, MD		22e. ADDRESS 134 Owensville Rd, West River, Md 20778		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Mar. 11 1984	23c. NAME OF CEMETERY OR CREMATORY St. Mary's	23d. LOCATION CITY OR TOWN COUNTY STATE Turner Falls - Franklin - MA	
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR FEB 28 1984		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

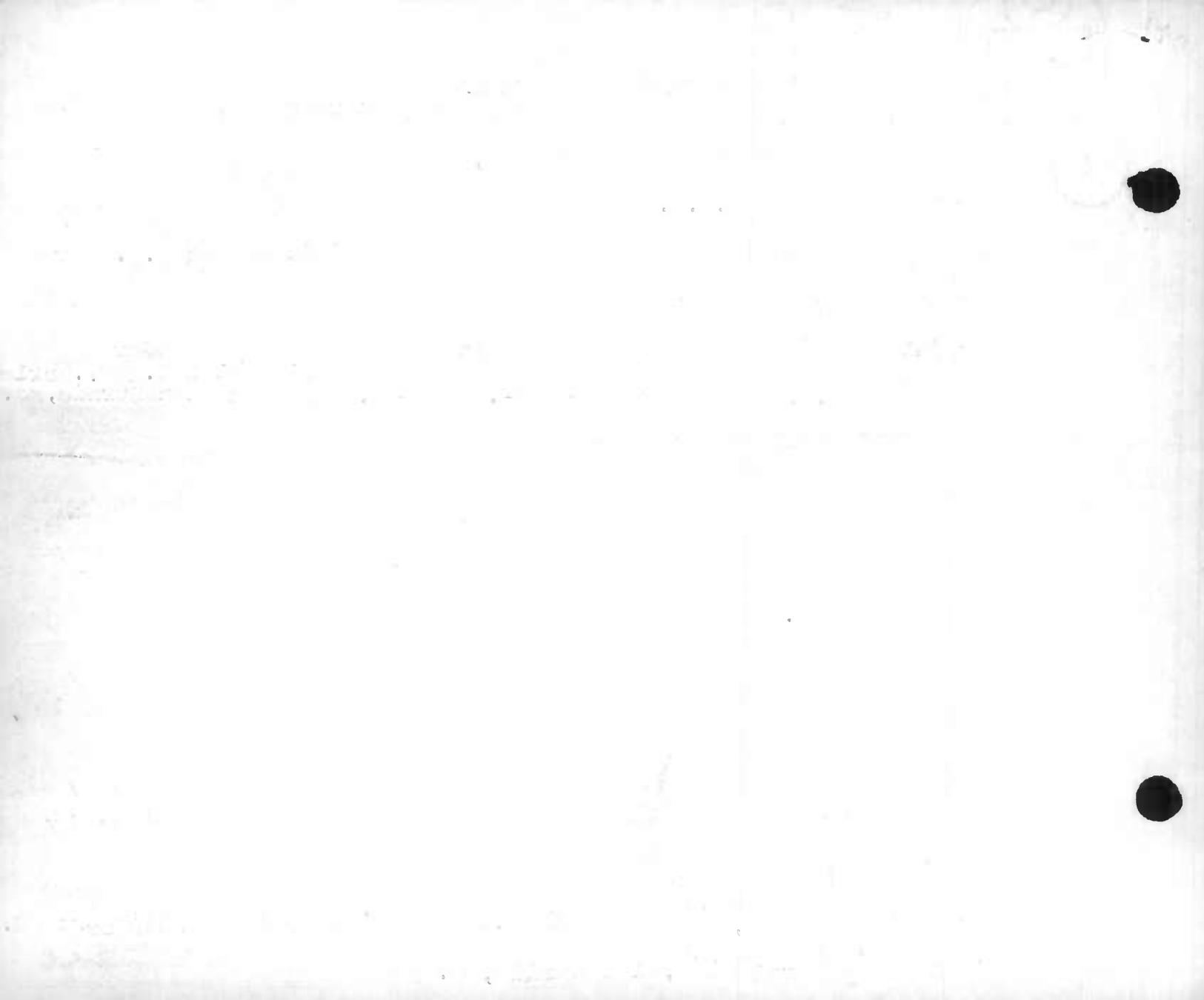
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALBERT JOSEPH SCANLON <i>Albert SCANLON</i>		2a. DATE OF DEATH MONTH DAY YEAR February 11, 1984		2b. HOUR 5:35 pm	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 28, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE Arundel County, MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Military (Ret)		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Anne	13c. CITY OR TOWN Crownsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Scanlon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Eder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W.W.II 218-14-6921		17. INFORMANT (Daughter) ADDRESS 22 1st Ave. Marley Mrs. Edith C. Bartlett Glen Burnie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) show the body after death.					
22b. SIGNATURE <i>H. Goldstein</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Goldstein M.D.		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE February 14, 1984		23c. NAME OF CEMETERY OR CREMATORY Security Process Inc.	
23d. LOCATION CITY OR TOWN Crownsville		COUNTY Baltimore		STATE Md.	
24. FUNERAL DIRECTOR NAME R. H. Hopkins		ADDRESS Singleton Funeral Home, Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR FEB 14 1984	
25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

William J Schaffer

2a. DATE OF DEATH

MONTH

DAY

YEAR

2-14-84

2b. HOUR

9:30 P.M.

3. SEX

MALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH

DAY

YEAR

9-25-01

6. AGE (IN YEARS LAST BIRTHDAY)

82

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN)

PA

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BACO

MD

10. CITY OR TOWN OF DEATH

Millercoille

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

1740 Baldwin Drive

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Retired

12b. KIND OF BUSINESS OR INDUSTRY

Self-Business

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. COUNTY

CHES. MAY

13c. CITY OR TOWN

Stone Hill

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

10112 Second Avenue 9999

14. FATHER'S NAME

ALVIN

MIDDLE

H

LAST

Schaffer

15. MOTHER'S MAIDEN NAME

Sarah

MIDDLE

Derhammer

LAST

Derhammer

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

179-24-5140

17. INFORMANT

Richard Schaffer

ADDRESS

1740 Baldwin Dr.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1850
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic Cancer - bone

DUE TO, OR AS A CONSEQUENCE OF

(c) Adenocarcinoma of prostate

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

9/83

1981

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

NONE

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (the hospital) attended the deceased from 2-8-84, 1984, to 2-14-84, 1984, that (I) (we) last saw the deceased alive on 2-10-84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

ERROL A. PHILLIPS

22e. ADDRESS

20 Ridgely Ave, Anns. MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Feb. 18, 1984

23c. NAME OF CEMETERY OR CREMATORY

Coplay Cemetery

23d. LOCATION

Coplay, Pennsylvania

24. FUNERAL DIRECTOR

NAME

Beall Funeral Home

16000 Annapolis Rd.

ADDRESS

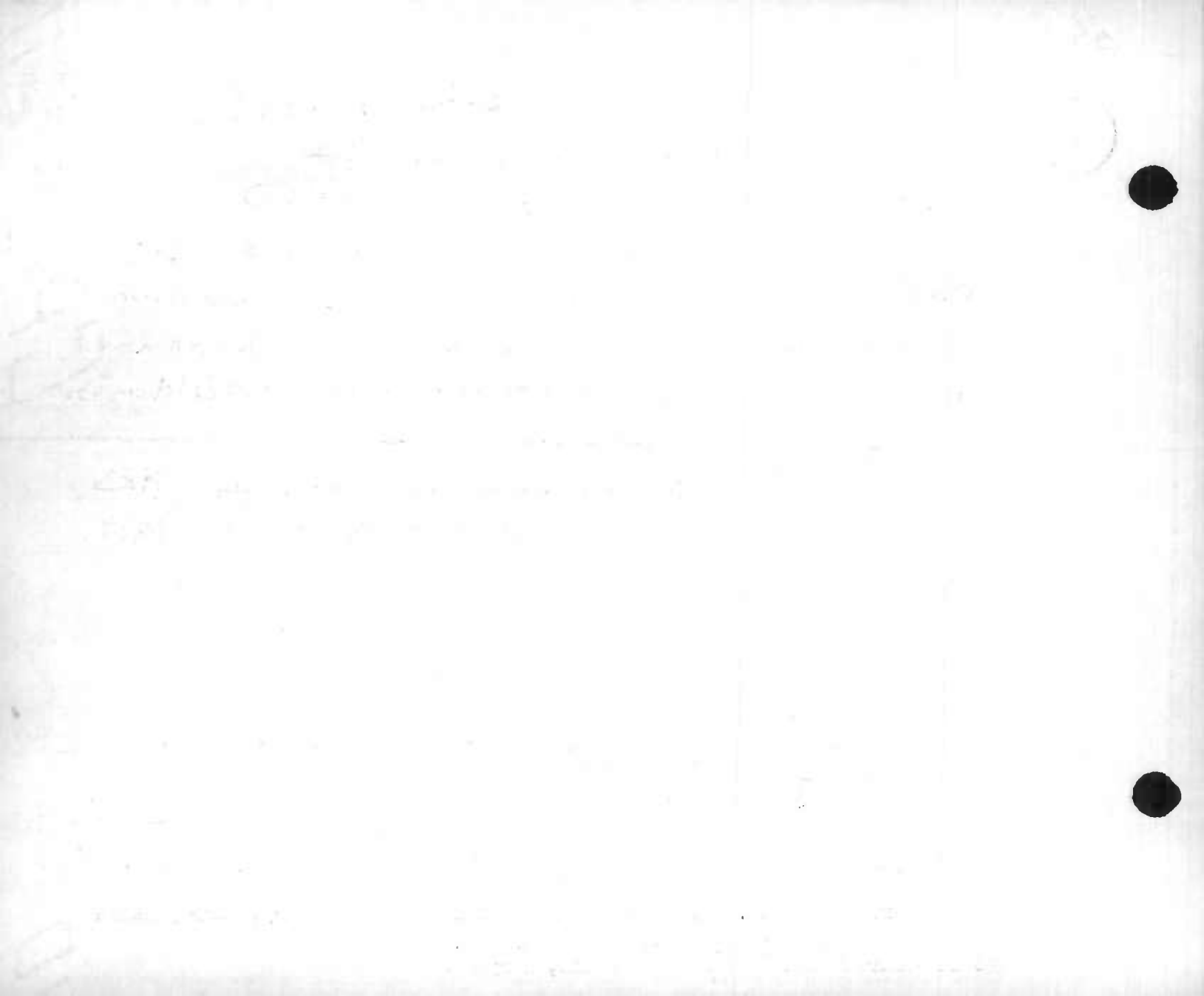
Bowie, Maryland

25a. DATE REC'D. BY REGISTRAR

FEB 21 1984

25b. REGISTRAR'S SIGNATURE

John Davidson-Rendell



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03248

1. DECEASED NAME (TYPE OR PRINT)		FIRST MAY	MIDDLE F	LAST SCHEELS	7a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 05, 1984		2b. HOUR 1043 PM
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 24 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (INDICATE FULL ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAITRESS		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
13a. STATE FLORIDA		13b. COUNTY PINELLAS		13c. CITY OR TOWN ST. PETERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 154-09-3818	
17. INFORMANT Tom Softley		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) CHD Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) CHD C & D Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		ADDRESS 752 CACTUS CT. MILLERSVILLE, MD. 21108	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 2-5 19 84 to 2-5 19 84, that (we) last saw the deceased alive on 2-5-19 84, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (if (we) (do not) view the body after death).							
22b. SIGNATURE MARC A. KAPLAN, M.D.		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-5-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 200 GLEN BURNIE, MARYLAND 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE FEB. 6 1984		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WESTVIEW BALTIMORE MD	
24. FUNERAL DIRECTOR NAME BARRANCO FUNERAL HOME		24b. DATE REC'D. BY REGISTRAR FEB 07 1984		24c. REGISTRAR'S SIGNATURE John J. Smith			



20% COTTON FIBER

CHIEF OF BUREAU



RECEIVED 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	EST
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LINWOOD ARMIGER SHAFER						2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 2, 1984			2b. HOUR 8:00 A M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 23 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed		12b. KIND OF BUSINESS OR INDUSTRY Florist			
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 441 West Hawthorne Rd. 21090			
14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Shafer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jeannette Armiger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-34-3165		17. INFORMANT (nephew) Mr. William H. Bond		ADDRESS: 210 A Donneybrook Lane Towson Md. 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) - Septic Shock DUE TO, OR AS A CONSEQUENCE OF (c) - PNEUMONIA CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1984 , to Feb 2, 1984 that (I) (we) lost saw the deceased alive on Feb 2, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. Reidner				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN REIDER, M.D.				22e. ADDRESS 1406 CRAIN HIGHWAY, SW #102 GLEN BURNIE, MARYLAND 21061							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6 Feb. 84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. City Md.			
24. FUNERAL DIRECTOR NAME Dean P. Charlton						ADDRESS Singleton Funeral Home Glen Burnie Md.		25a. DATE REC'D. BY REGISTRAR FEB 3 1984		25b. REGISTRAR'S SIGNATURE Sam J. Carver	

TO THE SECRETARY OF THE INTERIOR
WASHINGTON, D. C.
FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT
SALT LAKE CITY, UTAH
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing land management activities, possibly related to the 'SALT LAKE CITY' area mentioned in the header. The text is organized into paragraphs and possibly includes a list or table of data, but the specific details cannot be discerned.]



Item #16 3/16/84 mtb R#589

STATE OF MARYLAND

0 3 2 5 0

FOR
1- STATE
REGISTRAR

ELLEN

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ellen Davidson Shepherd			2a. DATE OF DEATH MONTH DAY YEAR 2/27/84		2b. HOUR 1:30 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 17, 1907	6. AGE (IN YEARS, LAST BIRTHDAY) 76 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD	13b. COUNTY AA	13c. CITY OR TOWN Harwood	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 20776 302 Harwood Road	
14. FATHER'S NAME FIRST MIDDLE LAST George Davidson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Emory			
16a. WAS DECEASED OVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213/48/3521		17. INFORMANT ADDRESS Ellen S. Holm - Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cu BREAST</u> 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/19/82</u> , 19____, to <u>2/27/84</u> , 19____, that (I) (we) last saw the deceased alive on <u>2/20/84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE SP Watkins for Dr E Cole				22c. DATE SIGNED 2/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SP WATKINS				22e. ADDRESS 51 Franklin St, Annapolis, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb 28, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION CITY OR TOWN Surtland		23e. COUNTY P.G.		23f. STATE MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis MD				25a. DATE REC'D. BY REGISTRAR FEB 28 1984	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randell					

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, list any injury, or other traumatic event, the medical examiner will be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, list any injury, or other traumatic event, the medical examiner will be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03251

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John A. Simms			2a. DATE OF DEATH MONTH 2 DAY 28 YEAR 84			2b. HOUR 3:49 <small>AM</small>	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH 6 DAY 11 YEAR 10	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL			9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND				13b. COUNTY A.A.	13c. CITY OR TOWN GALESVILLE		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS Benning Rd.			
14. FATHER'S NAME FIRST WILLIAM MIDDLE SIMMS LAST SIMMS				15. MOTHER'S MAIDEN NAME FIRST CHAROLETTE MIDDLE WELLS LAST WELLS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) W.W.11		17. INFORMANT ADDRESS Annapolis, Md. 21401 MARTHA SIMMS 42 College Creek Terrace			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

5742

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Cholecholethraus

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 2/27/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED cholecholethraus		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/25/84 , 19____, to 2/28/84 , 19____, that (I) (we) lost saw the deceased alive on 2/28/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John E. Leland				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/28/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Leland				22e. ADDRESS 108 Melvin Ave			

23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 3-2-1984		23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland	
24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A.				25a. DATE REC'D. BY REGISTRAR MAR 6 1984		25b. REGISTRAR'S SIGNATURE John E. Leland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

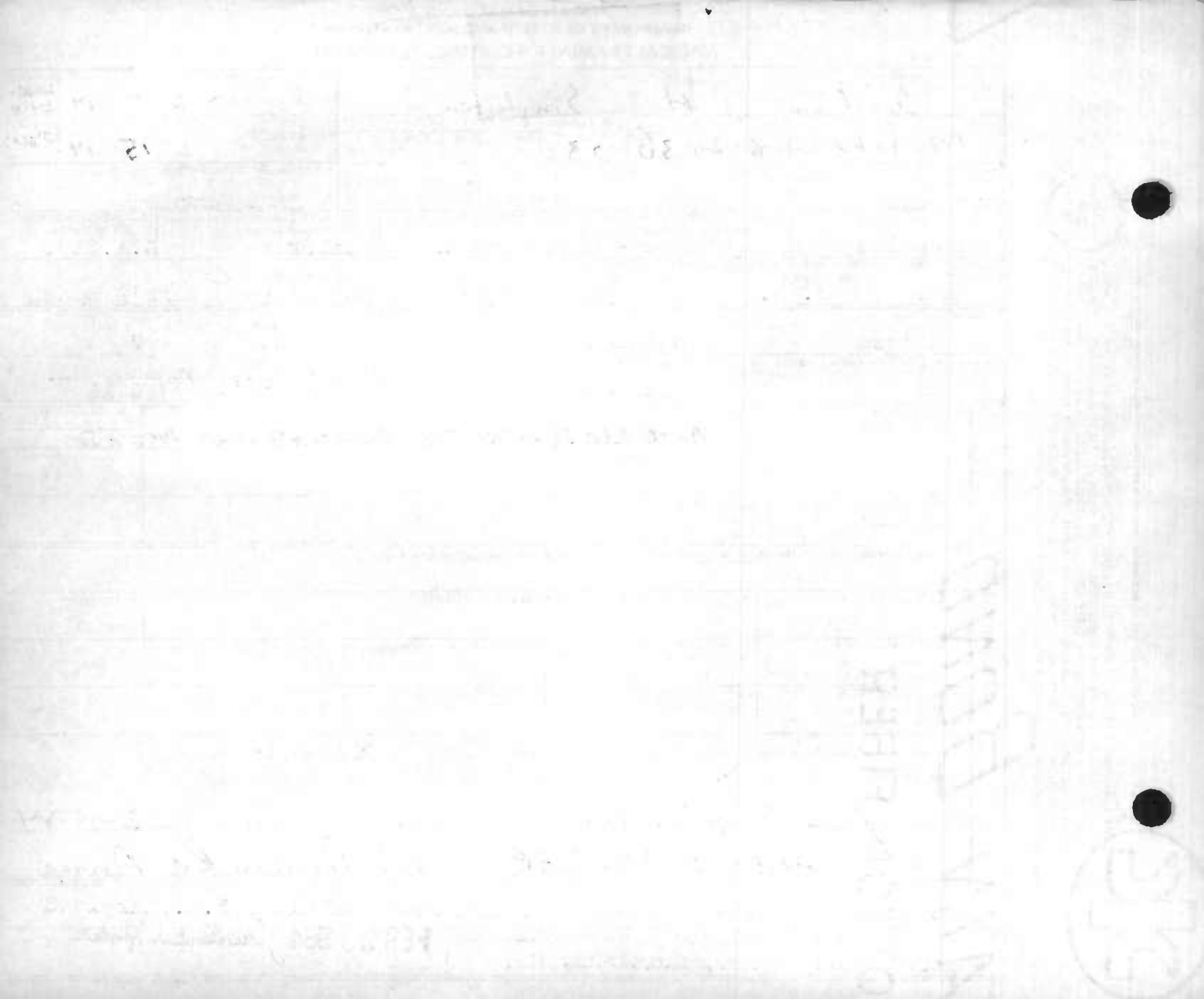
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William H Singleton			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2 17 1984			2b. HOUR 2:00-2:40 PM		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 6 DAY 26 YEAR 1955	6. AGE (IN YEARS) LAST 28 MONTHS 55 DAYS	7. UNDER 1 YR. MONTHS 55 DAYS	8. IF UNDER 24 HRS. HOURS 55 MIN.	2c. DATE PRONOUNCED DEAD 2 15 1984		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bay Ridge - Carr's Beach			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		
13a. STATE Md.			13b. COUNTY A. A.			13c. CITY OR TOWN Annapolis		
14. FATHER'S NAME FIRST Nelson MIDDLE Singleton LAST ?			15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE J. LAST ?			12b. KIND OF BUSINESS OR INDUSTRY A.A.Cty.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217-26-3204			17. INFORMANT 1060 Marlboro Rd. Lothian, Md. Mary Singleton, Wife 20711		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			2b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE James E Wheeler			TITLE (SPECIFY) Deputy			DATE SIGNED 2-15-84		
EXAMINER'S NAME (TYPE OR PRINT) JAMES E WHEELER			ADDRESS 910 Primrose Rd Annap.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 2-23-84			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		
24. FUNERAL DIRECTOR NAME Robt E Wilhelm			ADDRESS 4308 Suitland Rd., Suitland, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland		

FEB 28 1984



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MARIE Antoinette Smith				2a. DATE OF DEATH MONTH DAY YEAR Feb. 27, 1984			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 9 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1751 Old Annapolis Blvd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward David Hall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne Mason		16. SOCIAL SECURITY NO. 217-36-782306			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 217-36-782306		17. INFORMANT Dorothy Smith		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest (Narrow Angina) 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jacob E. Teitelbaum M.D.				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jacob E. Teitelbaum, M.D.				22e. ADDRESS 139 Old Solomons Island Rd., Annapolis, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 29, 1984		23c. NAME OF CEMETERY OR CREMATORY St. Anne's		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD	
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel-Annapolis, MD				25a. DATE REC'D. BY REGISTRAR MAR 6 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JAMES Oliver SUMERS Sr.						2a. DATE KNOWN OF DEATH MONTH 2 DAY 15 YEAR 1984		2b. HOUR 0030			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH 11 DAY 6 YEAR 22		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0		7c. DATE PRONOUNCED DEAD MONTH 2 DAY 15 YEAR 1984	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel		
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Foreman			12b. KIND OF BUSINESS OR INDUSTRY Sheet Metal	
13a. STATE Maryland			13b. COUNTY Queen Anne		13c. CITY OR TOWN Stevensville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 400 Kent Avenue 21666		
14. FATHER'S NAME FIRST Oliver MIDDLE J. LAST Somers						15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE Jones LAST Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. W.W. 2 214-18-5447			17. INFORMANT ADDRESS Theresa E. Somers 400 Kent Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac arrest - heart attack DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE James E. Wheeler				TITLE (SPECIFY) Deputy				DATE SIGNED 2-15-84			
EXAMINER'S NAME (TYPE OR PRINT) JAMES E WHEELER				ADDRESS 910 Primrose Rd Annapolis							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-18-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith			23d. LOCATION CITY OR TOWN Overlea, Balto Co. Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. ADDRESS 6224 Eastern Ave.						25a. DATE REC'D. BY REGISTRAR FEB 17 1984 REGISTRAR'S SIGNATURE John Davidson-Randall					

MEDICAL CERTIFICATION

SECTION 11

NOV 19 1944



NOV 19 1944

NOV 19 1944

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03255

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
EUGENE B. SONNTAG				2 8 84				11:26 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
MALE	Caucasian	4 13 03		80 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington DC	USA			Anne Arundel County, MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE,	PLAZA MANOR NURSING HOME			PLASTERER			Construction		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		20853	
MD		Montgomery	ROCKVILLE			4204 INDEPENDENCE ST.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Paul Anton Sonntag		Christine Riethmuller							
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		212 12 7341		ALENA LEONHARDT		SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT</u> 19 <u>82</u> to <u>FEB 8</u> 19 <u>84</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>FEB 8</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Ray Brodie, Jr MD</u> DEGREE _____			22c. DATE SIGNED <u>2/9/84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RAY Brodie, Jr MD</u>		22e. ADDRESS <u>844 N. CAYEY ST.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Feb 11, 1984</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring, Maryland</u>			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND				25a. DATE REC'D. BY REGISTRAR <u>FEB 16 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John P. ...</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03256

1- FOR
STATE
REGISTRAR

REG. NO.

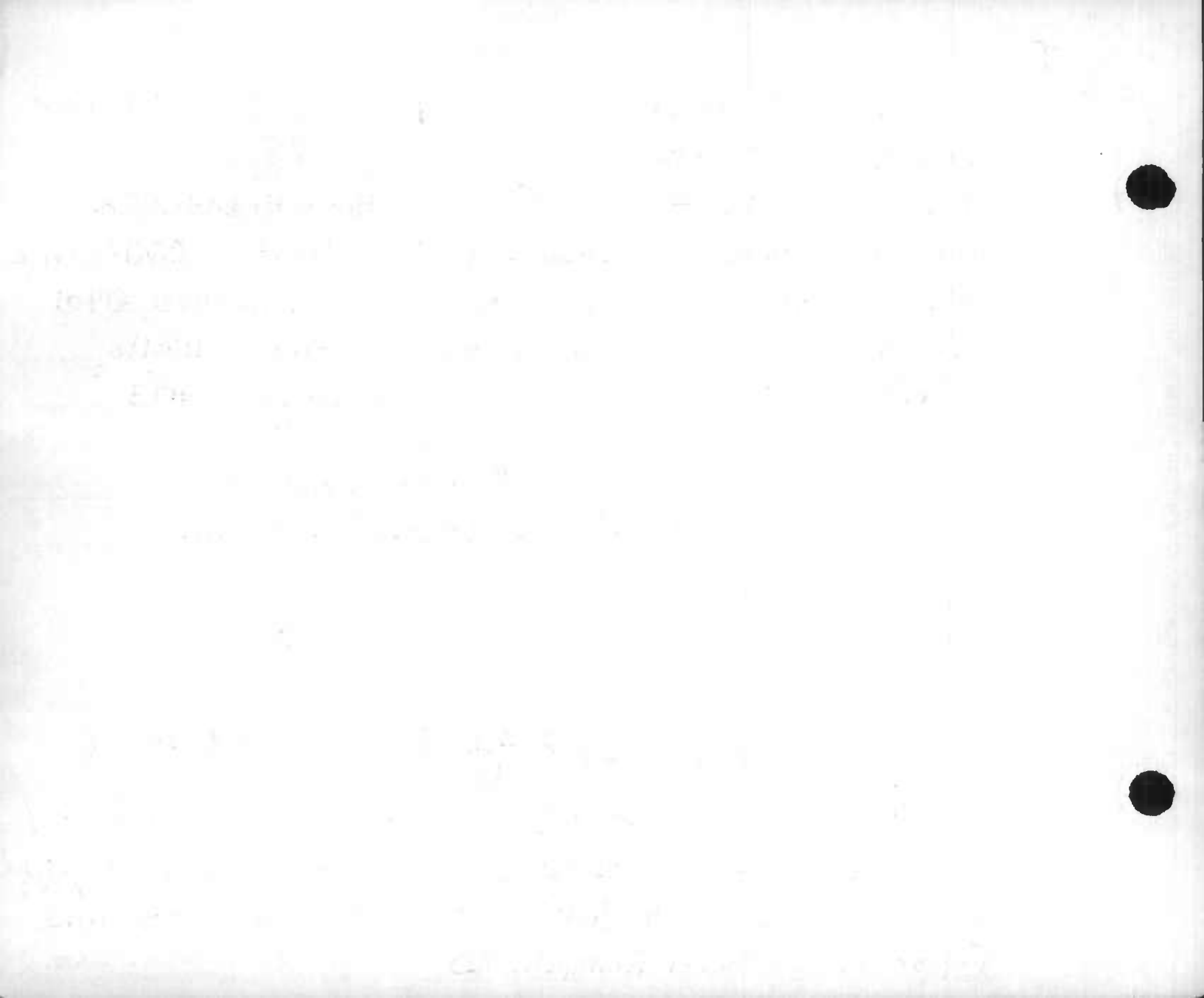
1. DECEASED NAME (TYPE OR PRINT) Robert (NMN) Stallings			2a. DATE OF DEATH MONTH 2 DAY 24 YEAR 84			2b. HOUR 4:20 P.M.							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 19 YEAR 95		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.							
10. CITY OR TOWN OF DEATH Annapolis			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY Civil Service				
13a. STATE MD			13b. COUNTY A.A.		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 607 Melvin Ave., 21401				
14. FATHER'S NAME FIRST John MIDDLE L. LAST Stallings			15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Ann LAST Wells			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF NO, UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-05-1230			17. INFORMANT Lillie L. Stallings ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock. DUE TO, OR AS A CONSEQUENCE OF (b) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT HOME				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 2/24/84 19 84 , to 2/24/84 19 84 , that (2) we lost view of the deceased above on 2/24/84 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)													
22b. SIGNATURE George P. Samaras				DEGREE				22c. DATE SIGNED 2/24/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George P. Samaras MD				22e. ADDRESS 205 Ridgely Ave Annapolis MD 21401									
23a. BURIAL, CREMATION, REMOVAL (RECEIPT) Burial				23b. DATE Feb 27, 1984				23c. NAME OF CEMETERY OR CREMATORY Hillcrest				23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD				25a. DATE REC'D. BY REGISTRAR FEB 28 1984				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal officer must be notified of such.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

63257

1. DECEASED NAME (TYPE OR PRINT) Nelle E. Sterling			2a. DATE OF DEATH MONTH 2 DAY 16 YEAR 84			2b. HOUR 10 AM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 7 DAY 23 YEAR 08		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Annapolis, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.			
10. CITY OR TOWN OF DEATH Annapolis, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15 N. Cherry St., Annapolis, Md. 21401				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BANKING		12b. KIND OF BUSINESS OR INDUSTRY RET	
13a. STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15 North Cherry Grove Ave	
14. FATHER'S NAME FIRST CHARLES MIDDLE HILL LAST HILL				15. MOTHER'S MAIDEN NAME FIRST HENRIETTA MIDDLE CORNELL LAST CORNELL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-38-1175		17. INFORMANT Betty J. Steehing		ADDRESS # 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARCINOMA of GallbladderAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**3 months**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **1560**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/11/84 19 83 to 2/16 19 84 , that (I) (we) last saw the deceased alive on 2/11/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John W. Mahaffay, M.D.				DEGREE		22c. DATE SIGNED 2/16/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Mahaffay, M.D.				22e. ADDRESS 703 Giddings Avenue, Suite L3, Annapolis			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT		23b. DATE 2/18/84		23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD.	
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL				ADDRESS ANNAPOILIS MD.		25a. DATE REC'D. BY REGISTRAR FEB 22 1984	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03258

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hermine U. Stevens			2a. DATE OF DEATH MONTH DAY YEAR 2 24 84			2b. HOUR 1A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 10 01		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AA Co MD.			
10. CITY OR TOWN OF DEATH Edgewater		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE Md			13b. COUNTY AACo		13c. CITY OR TOWN Annapolis	
14. FATHER'S NAME FIRST MIDDLE LAST Lewis Ullman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Adler			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 217 16 3160		17. INFORMANT ADDRESS Nona Luce, Annapolis, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonia 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2° CVA DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Feb 3 19 84 , to Feb 24 19 84 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. J. K. Howe						DEGREE MD		22c. DATE SIGNED 2/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. K. Howe Md						22e. ADDRESS West St Anna md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-25-84		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md		
24. FUNERAL DIRECTOR NAME ADDRESS Hardesty FH, 12 Ridgely Ave; Annapolis, Md. 21401						25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George Stines				2b. HOUR A. 12:02 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 - 19 - 1912		6. AGE (IN YEARS (LAST BIRTHDAY)) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Carpenter	
13a. STATE Md.		13b. COUNTY Anne Arundel		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 1208 Rock Hill Rd. 21122	
14. FATHER'S NAME FIRST MIDDLE LAST John Stines				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eda Elizabeth Times			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 224-03-4291		17. INFORMANT ADDRESS Mrs. Mildred Ruth Stines (wife) Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DIABETES AND HYPERTENSION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 1-3-84 19____, to 2-14-84 19____, that (I) (we) last saw the deceased alive on 2-14-84 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. Lankford Jr. M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-18-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR LANKFORD, JR., M. D.				22e. ADDRESS 2934 MOUNTAIN RD. PASADENA MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/21/84		23c. NAME OF CEMETERY OR CREMATORY Courtney Cemetery		23d. LOCATION Rogersville Hawkins Term.	
24. FUNERAL DIRECTOR'S NAME Fleming Barnes				24b. ADDRESS Benson, Md.		25. DATE REC'D. BY REGISTRAR FEB 23 1984	
				25b. REGISTRAR'S SIGNATURE			

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• *Journal of the American Medical Association*, 2000; 283: 2686-2692

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

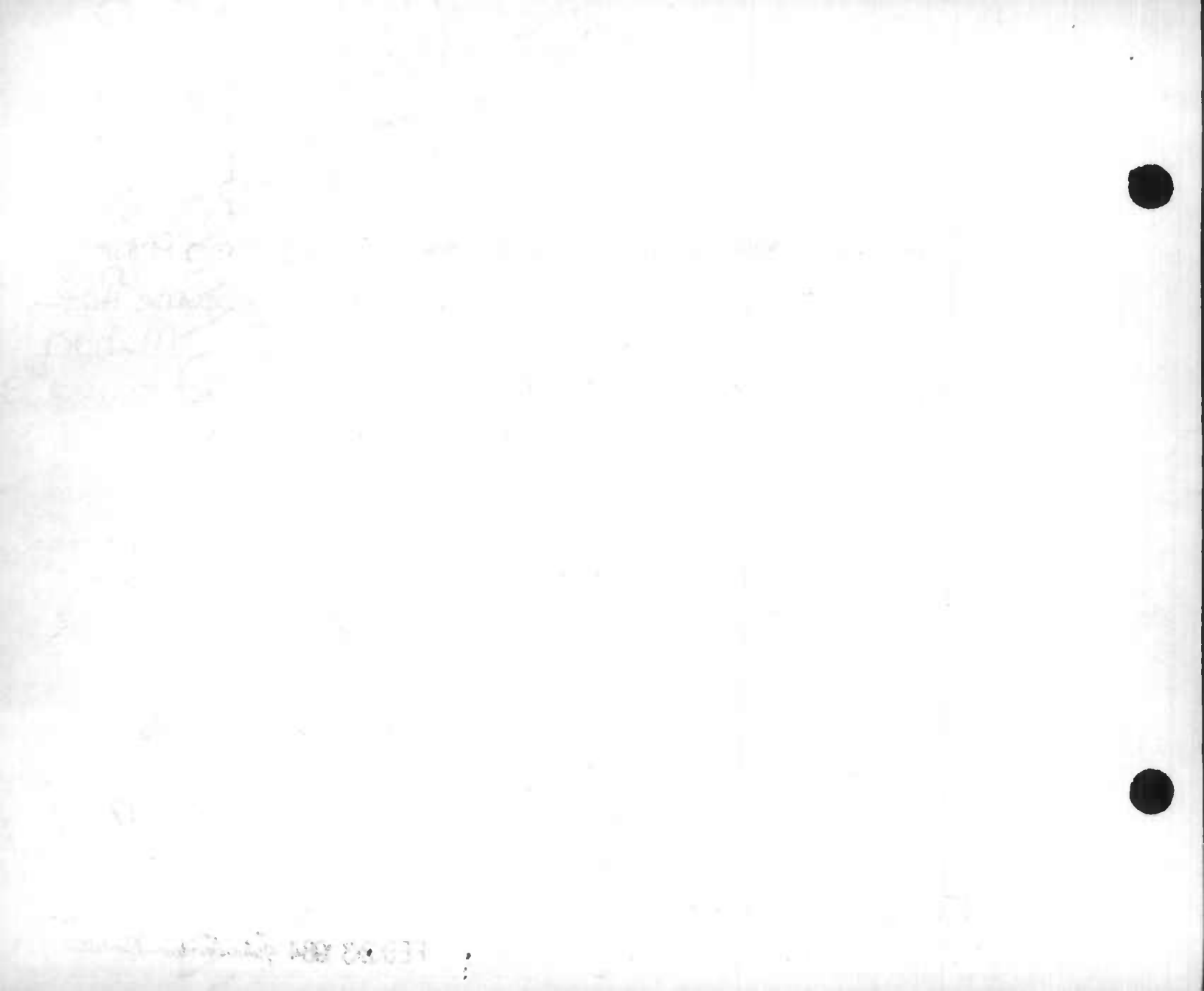
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) GEORGE STRINGER				2a. DATE OF DEATH MONTH 2 DAY 16 YEAR 84			
3. SEX MALE				2b. HOUR 5:14 P.M.			
4. RACE WHITE		5. DATE OF BIRTH MONTH 7 DAY 9 YEAR 93		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALCO MD.	
10. CITY OR TOWN OF DEATH Deale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6057 mebourne Ave		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Print Salesman		12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY AA 13c. CITY OR TOWN Deale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6057 mebourne Ave 20751			
14. FATHER'S NAME FIRST George MIDDLE F LAST Stringer		15. MOTHER'S MAIDEN NAME FIRST Morie MIDDLE Mahon LAST Mahon					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWT 578-05-6820		17. INFORMANT ADDRESS George F Stringer Jr - school #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Alzheimer's Disease. R died in his sleep.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 19 74 to presently 19 84 , that (I) (we) last saw the deceased alive on August 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (that) (did not) view the body after death.							
22b. SIGNATURE Carl A. Shuler DECEASEE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRKOLA-Phillip				22e. ADDRESS 20 Halsey Ave Annapolis MD 21401			
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 2-18-84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN Suitland COUNTY PG STATE MD	
24. FUNERAL DIRECTOR NAME Rouach Funeral Home ADDRESS Owings MD				25a. DATE REC'D. BY REGISTRAR FEB 23 1984 REGISTRAR'S SIGNATURE John Davidson Randall			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the body autopsied at the request of the State Dept. of Health and Mental Hygiene.

MEDICAL CERTIFICATION

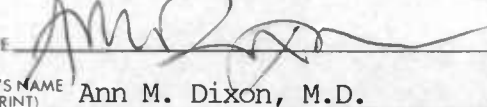
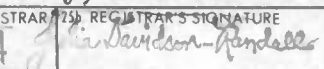
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MARY D. STUMP				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 7 1984			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 8 1910		6. AGE (IN YEARS, LAST BIRTHDAY) 73 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 286 SCOTTS GLEN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SSC.		12b. KIND OF BUSINESS OR INDUSTRY Contracting Co.	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN CARNY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 2311 WEATHERSVANE ROAD		13f. ZIP CODE 21234		14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL LASCHIAVA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRIDA MARCIANA	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-035674		17. INFORMANT FAMILY RECORDS		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 2028 DUE TO, OR AS A CONSEQUENCE OF (b) Lymphoma - Angioimmunoblastic Lymphadenopathy DUE TO, OR AS A CONSEQUENCE OF (c) With Dysproliferative (AIID) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~6 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR July 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 83 to Feb 7 84 , that (I) (we) lost saw the deceased alive on Jan 30, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE JAY H. JOSH, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAY H. JOSH, MD		22e. ADDRESS UMCC, Univ. of Md. Hospital, Balt. MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 9, 1984		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO. MARYLAND	
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES HARFORD		ADDRESS 8800 RD.		25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE Jan Davidson-Hendall	

BP _____

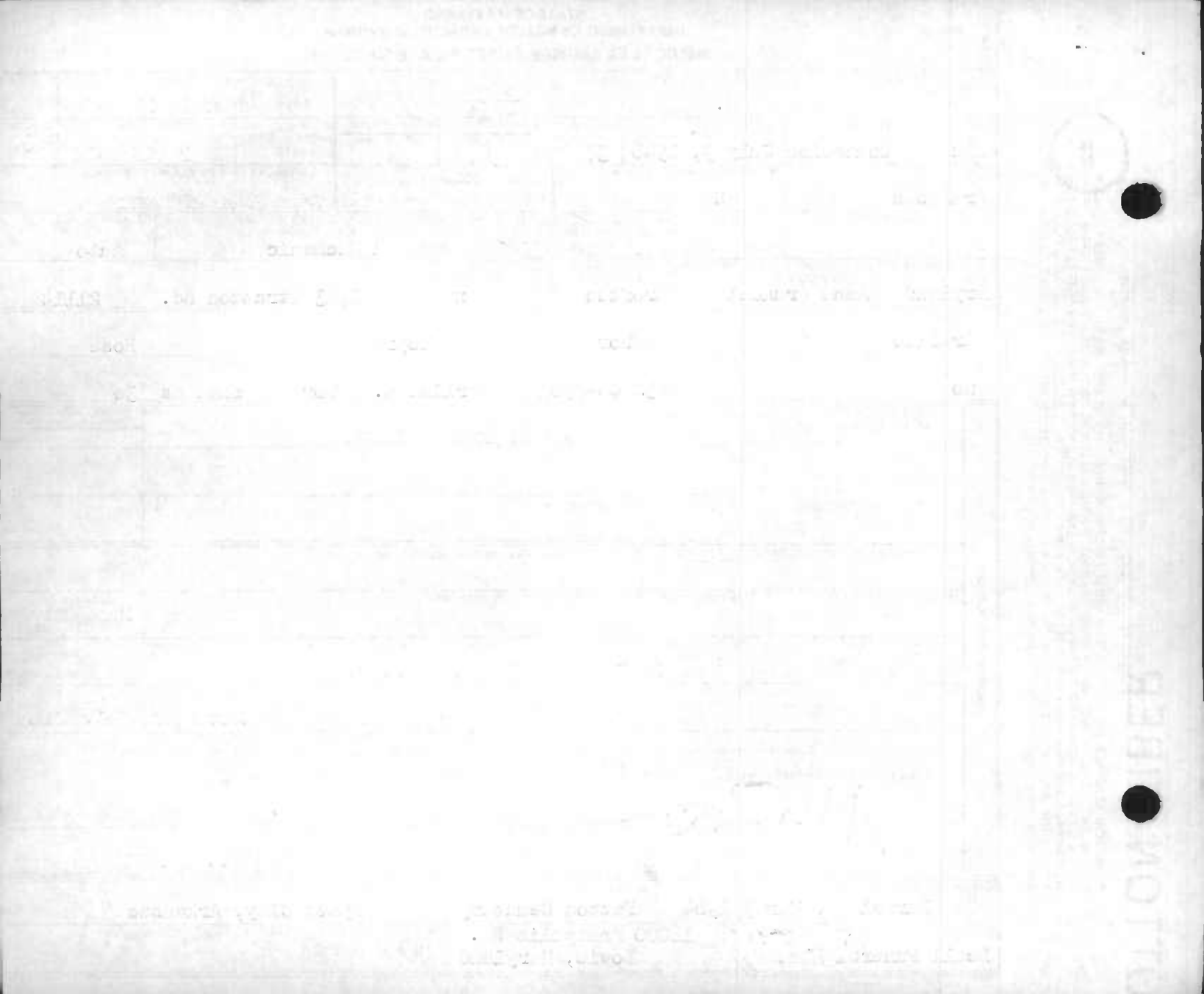
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 6 2	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROMA W. TABOR							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 27 1984		2b. HOUR 7:50 P M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 9, 1946		6. AGE (IN YEARS) LAST BIRTHDAY 37 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas			7b. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH Odenton			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) auto - wooded area off Patuxent Rd.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Crofton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1713 Stratton Rd. 21114			
14. FATHER'S NAME FIRST MIDDLE LAST Orville Tabor						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Moyra Rose					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 432-86-9901		17. INFORMANT Earline L. Tabor				ADDRESS same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9550 Gunshot wound of head (handgun) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? Head Only YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 2-27- 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) auto-wooded area		21f. LOCATION STREET CITY OR TOWN COUNTY STATE off Patuxent Rd., Odenton, Anne Arundel, Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 3-1-84			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar 5 1984		23c. NAME OF CEMETERY OR CREMATORY Patton Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Pyatt City, Arkansas	
24. FUNERAL DIRECTOR NAME Beall Funeral Home				ADDRESS 16000 Annapolis Rd. Bowie, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 9 1984			
								25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03263

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edwin J. Thalheimer</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Feb 18 84</i>		2b. HOUR 8 A M								
3. SEX <i>MALE</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>08 22 98</i>		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel County</i> MD.							
10. CITY OR TOWN OF DEATH <i>CROFTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CROFTON Convalescent Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Paperhanger</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>					
13a. STATE <i>MD.</i>			13b. COUNTY <i>BALTA</i>		13c. CITY OR TOWN <i>HARMANS</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>7532 Old Coaling Road 21077</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Adam Thalheimer</i>			15. MOTHER'S MAIDEN NAME FIRST LAST <i>Angelina Kuhlman</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>218-28-0358A</i>		17. INFORMANT ADDRESS <i>Ms. Anna Horner 7532 Old Coaling Harmons, Md.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *4280 Left ventricular failure*
DUE TO, OR AS A CONSEQUENCE OF (b) *Coronary heart failure*
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*minutes**minutes*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/18/84</i> to <i>2/18/84</i> , that (I) (we) lost saw the deceased alive on <i>2/18/84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Max Frank</i> DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/18/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MAX FRANK MD</i>				22e. ADDRESS <i>7575 Ritchie Hwy Glen Burnie Md 21061</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>2/18/84</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>				ADDRESS <i>Balto., Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 23 1984</i>	
				25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>			



20% COTTON FIBRE

100% COTTON FIBRE



FEB 23 1961

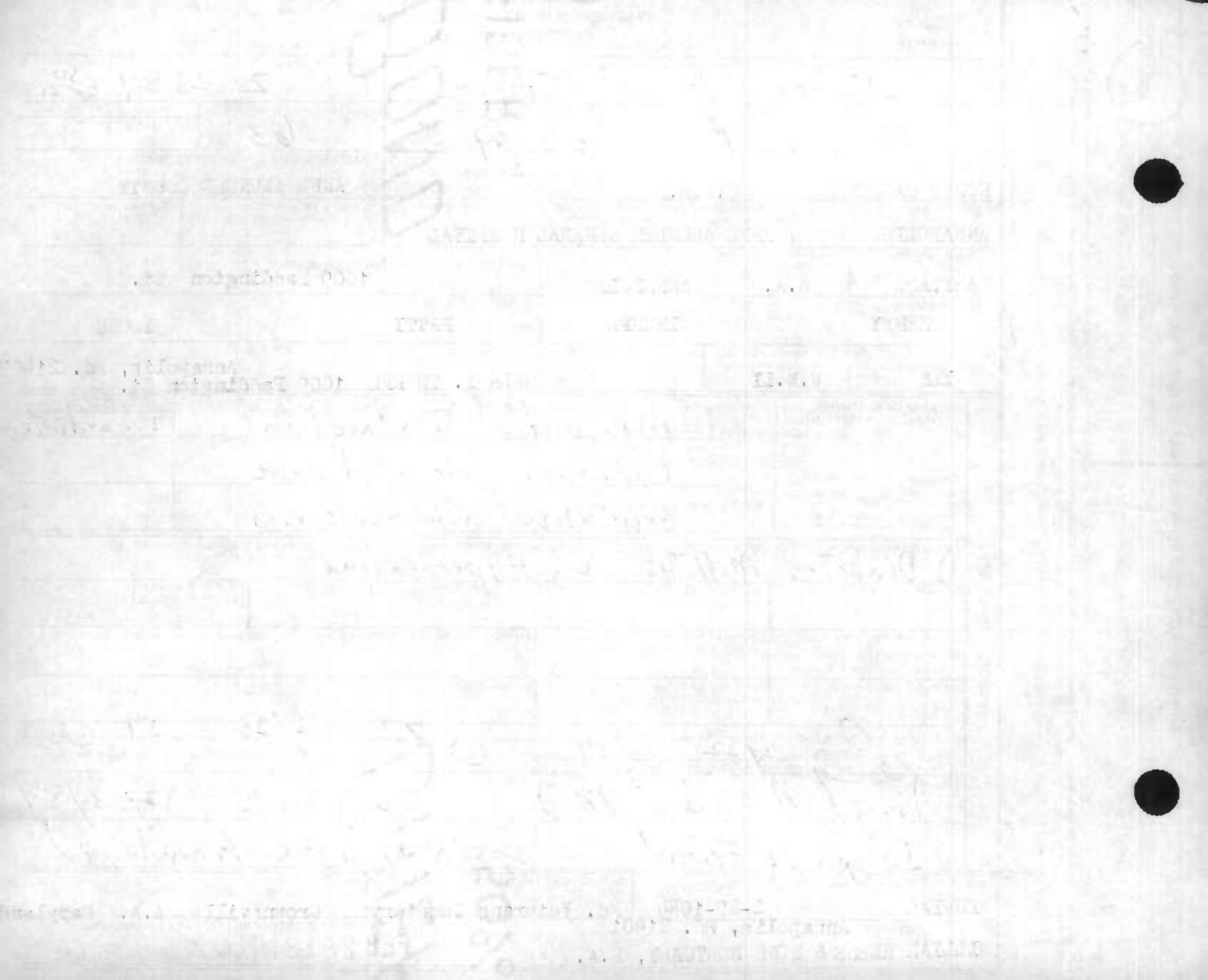
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03264			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2 23 84			
1 DECEASED NAME FIRST MIDDLE LAST James A Thorpe				2b. HOUR 6:50 a.m.			
3. SEX M		4 RACE B		5. DATE OF BIRTH MONTH DAY YEAR 06 29 20		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS / ZIP CODE 1009 Paddington St. 21403			
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY THORPE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PATTY YOUNG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. W.W.II		17. INFORMANT ADDRESS LULA I. THORPE 1009 Paddington St. Annapolis, Md. 21403			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Myocardial Infarction							
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery disease							
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 1) Diabetes Mellitus 2) Hypertension							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 2/22 19 84, to 2/23 19 84, that (1) (we) lost saw the deceased alive on 2/22 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Friend M.D.				22c. ADDRESS 205 Ridgely Ave Annapolis, Md.		22d. DATE SIGNED 2/23/84	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-27-1984		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Maryland	
24. FUNERAL DIRECTOR Annopolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.				25a. DATE REC'D. BY REGISTRAR FEB 28 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

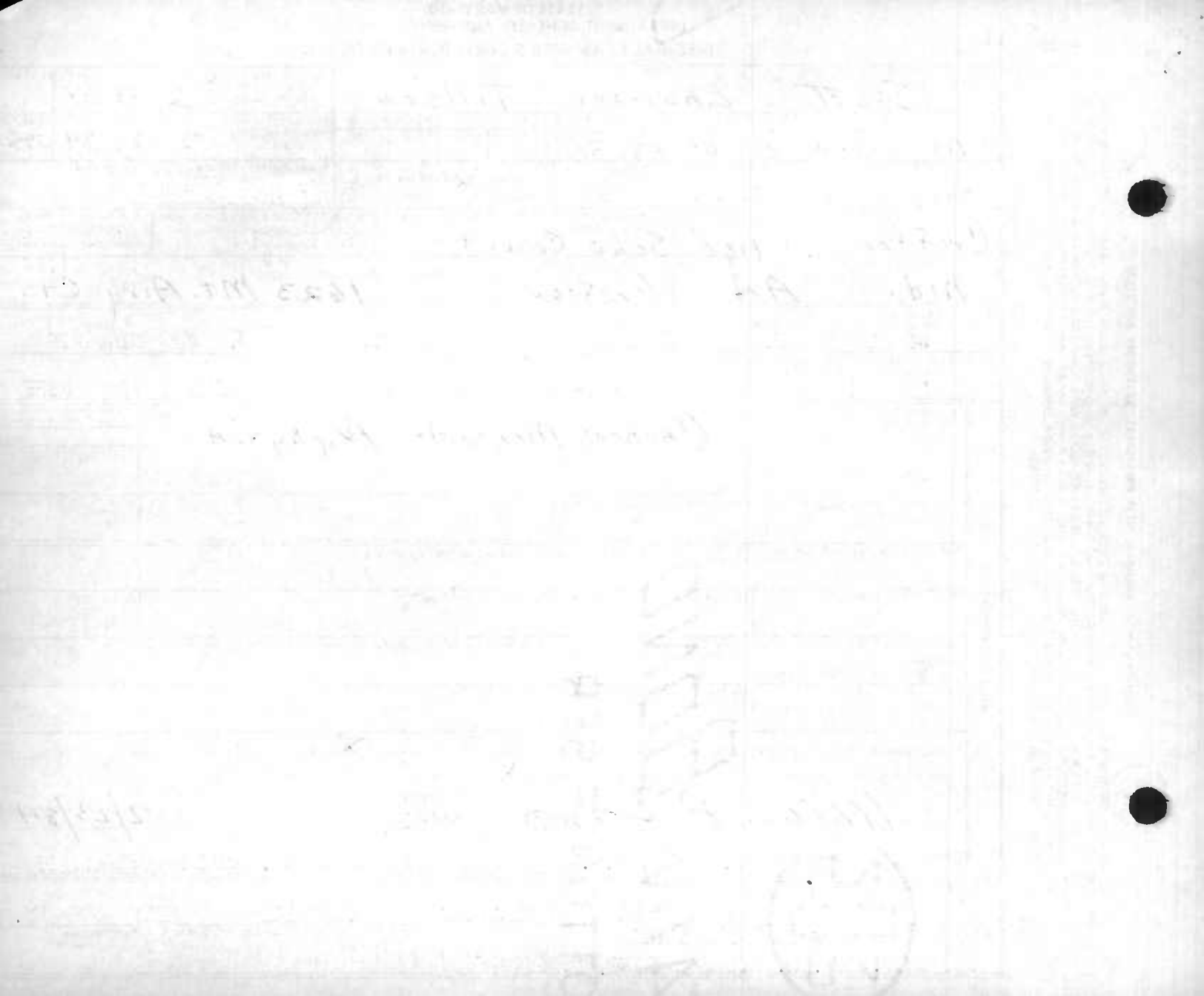
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SCOTT Lawrence Tillson			2a. DATE KNOWN DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2 23 1984			2b. HOUR M																	
3. SEX M		4. RACE Can		5. DATE OF BIRTH MONTH DAY YEAR 07 04 53		6. AGE (IN YEARS) LAST BIRTHDAY 30 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 2 23 1984		7d. HOUR 0950 M											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.											
10. CITY OR TOWN OF DEATH Crofton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1100 Soho Court -				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STATISTICIAN				12b. KIND OF BUSINESS OR INDUSTRY CENSUS BUREAU											
13a. STATE Md.				13b. COUNTY AA				13c. CITY OR TOWN Crofton				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1633 Mt. Airy Ct.				21114			
14. FATHER'S NAME FIRST MIDDLE LAST DONALD E. TILLSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARJORIE M. SINCLAIR				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 218-56-6607				17. INFORMANT ADDRESS SHARON M. TILLSON SAME AS 13 WIFE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Asphyxia. 9520 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE William P. Jones, MD				TITLE (SPECIFY) Deputy MEDICAL EXAMINER								DATE SIGNED 2/23/84											
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.				ADDRESS 695 America Ct. Davidsonville 21035																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 2/27/84				23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.											
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS								25a. DATE REC'D. BY REGISTRAR FEB 29 1984				25b. REGISTRAR'S SIGNATURE Davidson-Randell											
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																							

15

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03288

1- FOR
STATE
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST GLORIA	MIDDLE JEAN	LAST TROUTMAN	MONTH DAY YEAR FEBRUARY 01, 1984			0225 AM		
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1939	6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY -		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STREET ADDRESS / ZIP CODE					
13a. STATE Maryland	13b. COUNTY A.A. Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1207 Guilford Rd. 21061				
14. FATHER'S NAME FIRST MIDDLE LAST Reginald - Lowe			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary - Kholway					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-36-5663			17. INFORMANT Gerard Troutman		
			ADDRESS 1207 Guilford Rd.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory failure 3352 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Cachexia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years year
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/31, 1984 to 2/1/84 , that (I) (we) last saw the deceased alive on 1/31/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Frank		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX C. FRANK, M.D.		22e. ADDRESS 7575 RITCHIE HWY SOUTH EAST GLEN BURNIE, MARYLAND 21061					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-4-1984	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, (A.A.Co) Md.
24. FUNERAL DIRECTOR NAME Raymond C. Fink		25. DATE OF C.D. BY REGISTRAR FEB 01 1984	
24. FUNERAL DIRECTOR ADDRESS Glen Burnie, Md.		25. REGISTRAR'S SIGNATURE John J. Conish	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "AT WORK" there must be any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove participants. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 36 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03267

EST

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
DAVID NORMAN VACEK		FEBRUARY 19, 1984		0650 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	Cauc.	6-22-1941	42 YRS	ANNE ARUNDEL COUNTY MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Balto., Md.	U.S.A.		Desiel Mech.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL		Const.		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland		A.A.	Glen Burnie	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	7852 Americana Cir. 21061
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
James Jerome Vacek		Delores Mary Lickey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		U.S.A.R. '66 217-38-5091		Debra Ann Vacek 7852 Americana Cr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>					
4300 DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>Massive Intracerebral & Subarachnoid Hemorrhage</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>Chronic Liver Disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
<u>Chronic Alcoholism</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 2-18, 19 84, to 2-19, 19 84, that (1) (we) lost saw the deceased alive on 2-19, 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Edward Sierman				2-19-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
EDWARD N. SIERMAN, M.D.		7422 BALTIMORE-ANNAPOLIS BLVD GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	2-23-84	Glen Haven Mem. Pk.		Glen Burnie (A.A.) Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Raymond C. Fink		FEB 22 1984		Julia Davidson-Randall	
ADDRESS					
Glen Burnie, Md.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helena A. Vahtras			2a. DATE OF DEATH MONTH DAY YEAR 2/ 22 84		2b. HOUR 6:15P ^M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 20 15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6812 Fort Smallwood Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home Maker
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. COUNTY A.A.	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Alex Birk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hallikas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-12-7113		17. INFORMANT ADDRESS Julia Lynch 523 Chalet West, Millersville Maryland 21108	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Severe hypertension, Hypobolemic, peripheral neuropathy					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/10/83 , to Barney , 19 83 , that (I) (we) lost saw the deceased alive on 2/19/84 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Nick P. Moutsos		DEGREE MD		22c. DATE SIGNED 2/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NICK P MOUTSOS MD		22e. ADDRESS 95 Aqueduct Rd, Glen Burnie, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/24/84		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md		23e. DATE REC'D BY REGISTRAR FEB 27 1984			
24. FUNERAL DIRECTOR George J. Gonce		25. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LENORA MARY VANDALL				2b. HOUR 12:50 AM			
3 SEX Female		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 1-6-1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTHARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE New Jersey				13b. CITY OR TOWN Williams Twn		13c. STREET ADDRESS / ZIP CODE unknown 99999	
14. FATHER'S NAME FIRST MIDDLE LAST James - Sefers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 135-54-5658		17. INFORMANT ADDRESS D.L. Vandall New Jersey 609-629-5452			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous Cell Carcinoma</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Functional Rhythm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-7</u> 19 <u>84</u> , to <u>2-15</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2-15</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> DEGREE				22c. DATE SIGNED 2/15/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) DALJIT S. SAWHNEY, M.D.	
22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Rainelle, W. Va.		23d. LOCATION CITY OR TOWN COUNTY STATE Rainelle - W. Va.	
24. FUNERAL DIRECTOR NAME Raymond C. Fink Glen Burnie, Md. 21061				25a. DATE REC'D. BY REGISTRAR FEB 22 1984			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.		EST	
1. FOR STATE REGISTRAR				2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT) ELEGER WALKER				MONTH DAY YEAR FEBRUARY 27, 1984		1228 PM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11-25-12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Tom Walker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Evie Green		13e. STREET ADDRESS / ZIP CODE 398 Woods Rd. Pasadena 21122			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE WAR OR DATES WW 2		16b. SOCIAL SECURITY NO. 220-07-2724		17. INFORMANT Lilly Mae Walker		ADDRESS 398 Woods Rd. Pasadena 21122	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Venoculor fibrillation 4960 DUE TO, OR AS A CONSEQUENCE OF (b) congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) chronic obstructive Lung Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 2-27 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Sang C. Do</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-27-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOH, M.D.				22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-3-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion CH.		23d. LOCATION CITY OR TOWN COUNTY STATE Magothy A.A. MD	
24. FUNERAL DIRECTOR NAME Charles A Rice FSPA				ADDRESS 1300 Eutaw Place		25a. DATE REC'D. BY REGISTRAR (S), REGISTRAR'S SIGNATURE MAR 6 1984 <i>Davidson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

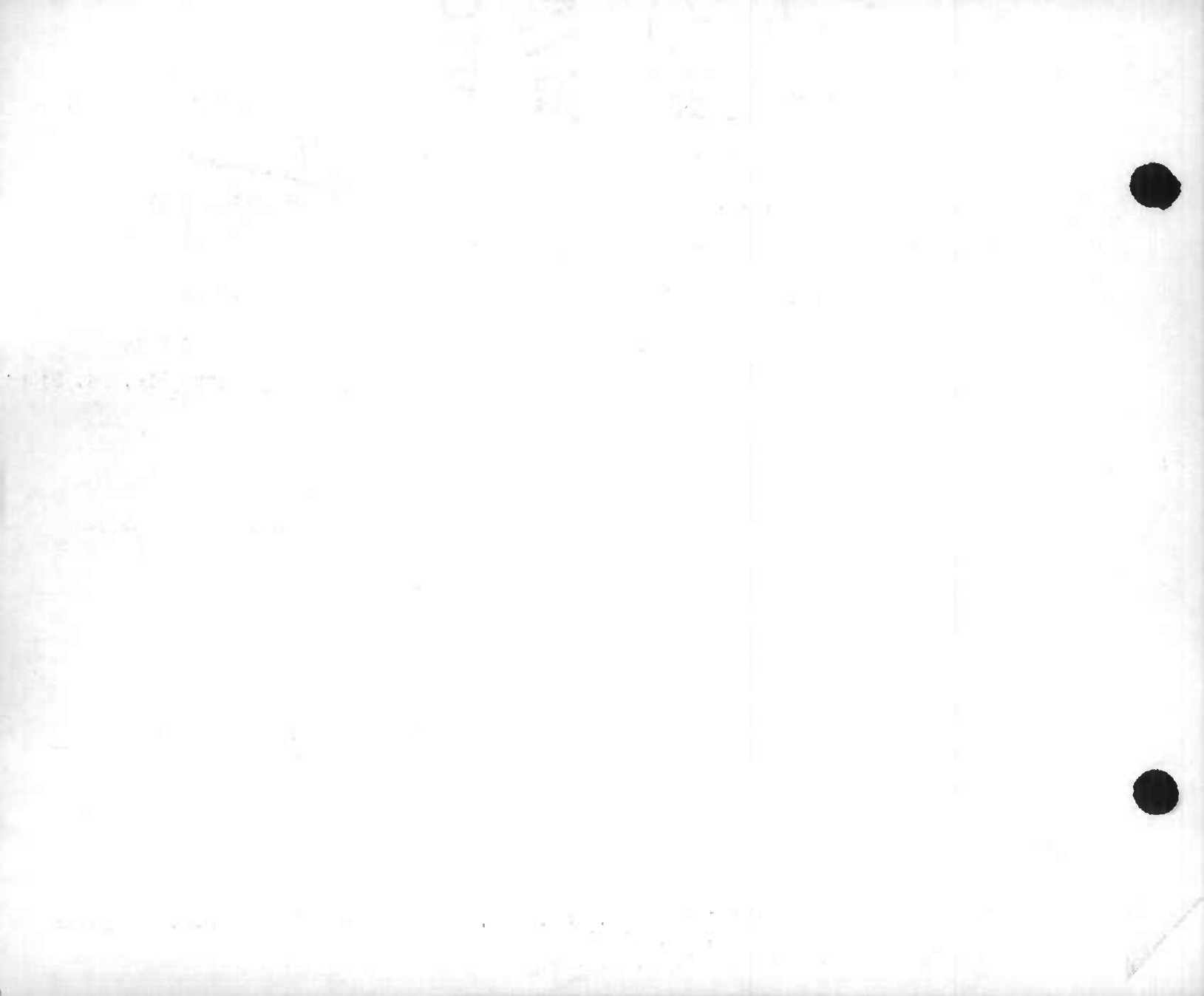
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03271			
1. FOR Item 4 3-6-84 cn 1- STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2-16-84			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES Q WALKER				2b. HOUR 7:00 PM			
3. SEX MALE		4. RACE Black 2		5. DATE OF BIRTH MONTH DAY YEAR 7 18 12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY WALKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROBERTA COUSIN		13e. STREET ADDRESS / ZIP CODE 4 Bunche Street 21401			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MARGARET WALKER 4 Bunche Street Annapolis, Md. 21401			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3989 Due to, or as a consequence of (b) Congestive heart failure (c) Rheumatic heart disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Months Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/16/84, 1976, to 2/16/84, 1984, that (I) (last) saw the deceased alive on 2/16/84, 1984, and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. Cituapit DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/16/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Cituapit				22e. ADDRESS 8 CLEVELAND AVE SEVERNA PARK MD 21141			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-21-1984		23c. NAME OF CEMETERY OR CREMATORY Md. Nat. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401				25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE G. Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

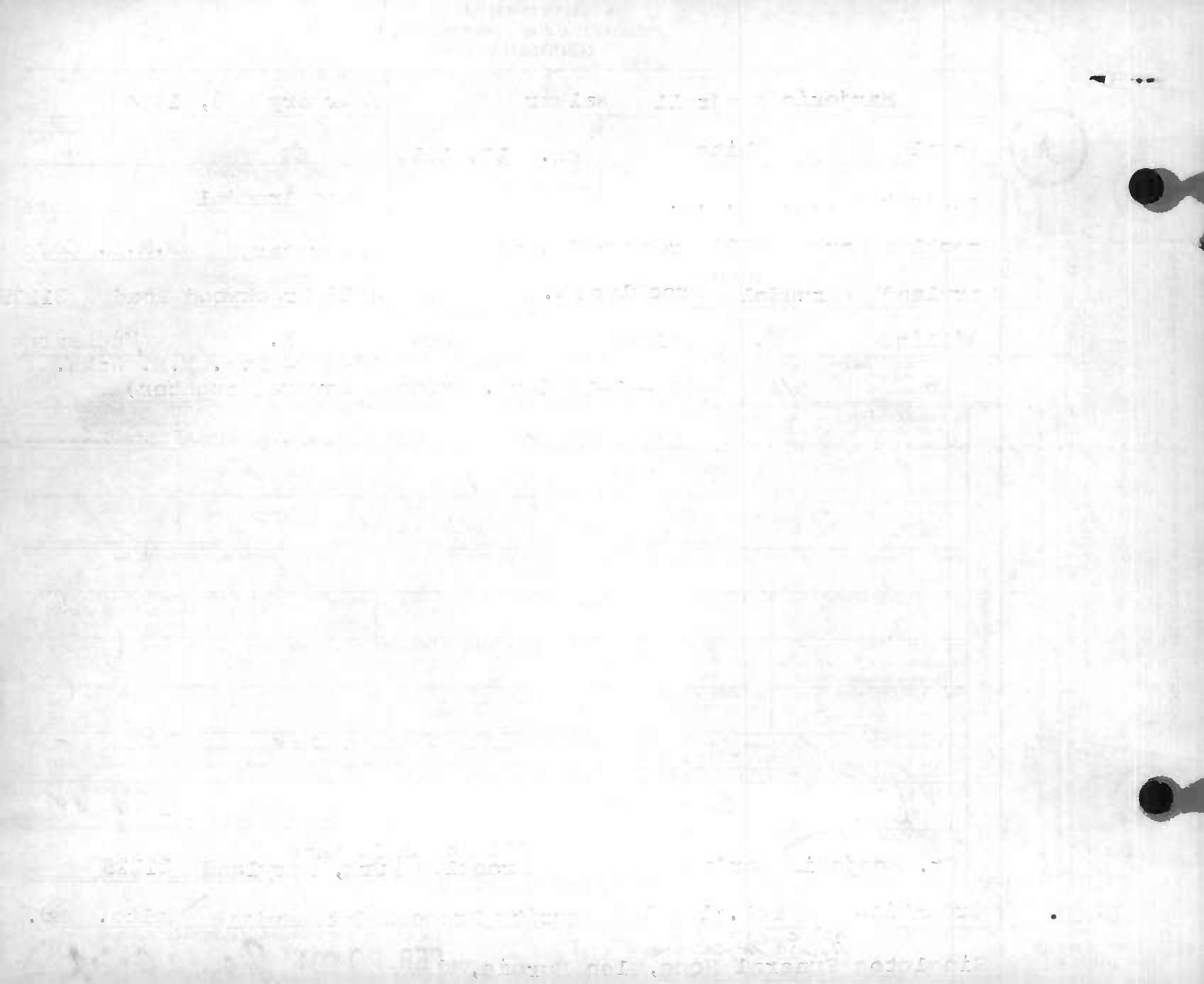
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marjorie Kendrell Walker			2a. DATE OF DEATH MONTH DAY YEAR February 8, 1984			2b. HOUR M A			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Brooklyn Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4926 Brookwood Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY F.M.C. Corp	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Brooklyn Pk.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4926 Brookwood Road 21225	
14. FATHER'S NAME FIRST MIDDLE LAST William K. Walker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora I. MacLearn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 230-07-1096		17. INFORMANT Mrs. Suzanne Levere (Daughter)		3848 94 Ave. N.E. Wash.		98004	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Generalized DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-7 , 19 84 , to 2-8 , 19 84 , that (I) (we) last saw the deceased alive on 2-2 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Benjemin Berdann				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-9-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Benjemin Berdann				22e. ADDRESS 606 Hammonds Lane Brooklyn Park, Maryland 21225					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb. 11, 1984		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.			
24. FUNERAL DIRECTOR NAME R. E. Hopkins				25a. DATE REC'D. BY REGISTRAR FEB 10 1984		25b. REGISTRAR'S SIGNATURE John J. Carver			
26. FUNERAL HOME Singleton Funeral Home, Glen Burnie, Md.									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03273

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frances Ellen WALKUP			2a. DATE OF DEATH MONTH February DAY 29 YEAR 1984			2b. HOUR 10:40 A M				
3. SEX female		4. RACE white		5. DATE OF BIRTH June 19, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH AA Co. MD.				
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7 Willowdale St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE MD			13b. COUNTY AA			13c. CITY OR TOWN Glen Burnie			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Owen Nicely			15. MOTHER'S MAIDEN NAME MIDDLE LAST Stella Fleshtman			16. SOCIAL SECURITY NO. 212/34/8292				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212/34/8292			17. INFORMANT ADDRESS Baltimore, MD G. Dean Clark (daughter)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and generalized bleeding 2051 DUE TO, OR AS A CONSEQUENCE OF, (b) Blast Crisis of Chronic Myeloid Leukemia DUE TO, OR AS A CONSEQUENCE OF, (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION /			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED /			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1982 , 19____, to 2/1/84 , 19____, that (I) (we) lost saw the deceased alive on 2/1/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Rouben Jiji, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/1/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROUBEN JIJI, MD			22e. ADDRESS University of Md Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5 March 1984			23c. NAME OF CEMETERY OR CREMATORY End of the Trail			23d. LOCATION CITY OR TOWN COUNTY STATE Clintonville, Greenbrier W. VA.	
24. FUNERAL DIRECTOR Singleton Funeral Home			ADDRESS Glen Burnie, MD			25a. DATE REC'D. BY REGISTRAR MAR 1 1984		25b. REGISTRAR'S SIGNATURE Juha Davidson-Rendell		

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Best of luck
and good night

2/1/84

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2/1/84

Good night
and good luck

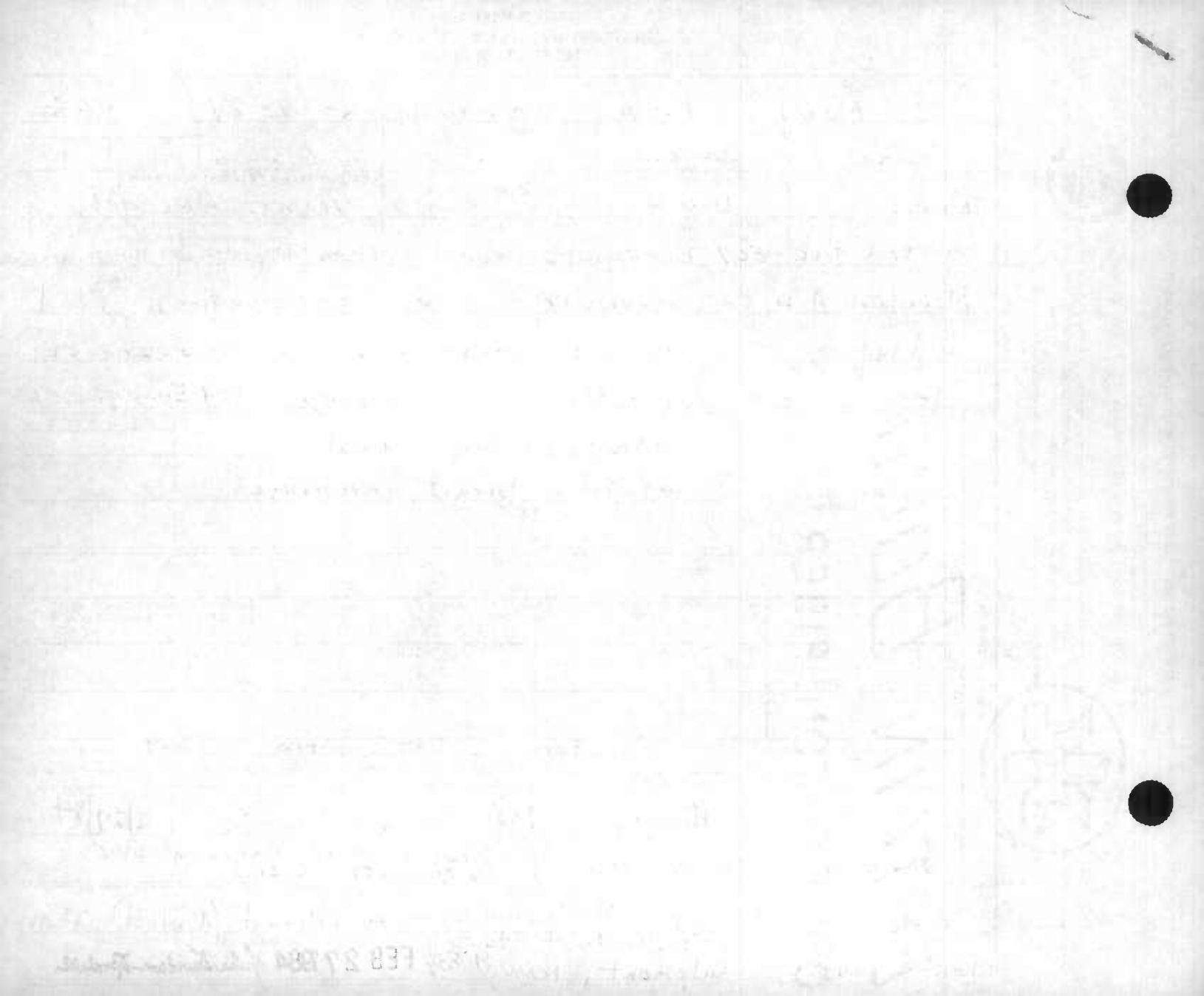
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", item 18 should show any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		
		Mary Anna Wascavage					2-27-84		6 ³⁰ pm		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Cauc.		7-16-20		63					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Penn.		U.S.A.				Anne Arundel MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Saveria Park		509 Evergreen Road				Data Processing		Westinghouse			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		A.A. Co.		Severna Park		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		509 Evergreen Road			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Michael - Mazuk		Anastashia - GRZMONSKI									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
Yes		unk		119-12-3363		Joe Wascavage		509 Evergreen			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio respiratory arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1749 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic breast carcinoma											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Feb 1980, to Feb 1984, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
DAVID S. ETTINGER MD		MD						2/27/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
DAVID S. ETTINGER MD		Johns Hopkins Oncology Center				Baltimore MD 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3-1-84		St. Casimir Cemetery		Kulpmont (North'd) Penn.					
24. FUNERAL DIRECTOR NAME		1024 Chestnut Sts.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Charles Lucas		Kulpmont, Penn.		17834 FEB 27 1984		Julia Davidson-Rendell					

BP _____



#10, per F.H. & doc.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03275

1. FOR
STATE
REGISTRAR

2/21/84 kam

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen Isabel Waters			2a. DATE OF DEATH MONTH DAY YEAR Feb 8, 1984			2b. HOUR 7:00 M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb 9, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Edgewater		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1526 Brice Circle Saunders Pt.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerical		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. STATE Md.		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1526 Brice Circle Saunders Pt. 21037	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Lee Manders			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary W. Adams			16. ADDRESS 1526 Brice Circle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 1918-1919		17. INFORMANT Robert W. Manders Edgewater, Md. 21037				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>Coronary Artery Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/29</u> , 19 <u>83</u> , to <u>2</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>10/29</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Robert W. Manders</u>				DEGREE M.D.		22c. DATE SIGNED 2/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/11/84		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Shenandoah Schuylkill Co. Pa.	
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home Ann. Md.				25a. DATE REC'D. BY REGISTRAR FEB 15 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST HARRY Edward WEBER				2b. HOUR 10:45 A M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1899		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS 84 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.- Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry T. Weber		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Hahn		13e. STREET ADDRESS 8435 Bay Road, 21122			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-2478		17. INFORMANT Mr. Robert L. Kite ADDRESS 4838 Ridge Road Baltimore, Maryland 21237			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5860 End stage renal disease DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/10/84 to 2/11/84 that (I) (we) last saw the deceased alive on 2/10/84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE RECEP EROL				DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RECEP EROL, M.D.				22e. ADDRESS 25 HOSPITAL DRIVE, #104, GLEN BURNIE, MD. 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-13-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore Maryland	
24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Road Randallstown, Maryland 21133				25. DATE REC'D. BY REGISTRAR FEB 14 1984			

26. REGISTRAR'S SIGNATURE
Julia Anderson-Randall

GEN. CO. ON FILE

CHIEFLAIN



1st Lt. J. W. [illegible]

1st Lt. J. W. [illegible]

1st Lt. J. W. [illegible]

1st Lt. J. W. [illegible]

1st Lt. J. W. [illegible]

1st Lt. J. W. [illegible]

1st Lt. J. W. [illegible]

1st Lt. J. W. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Ellen S. Welch						2a. DATE OF DEATH MONTH 2 DAY 29 YEAR 84		2b. HOUR 2010 M			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 10 DAY 13 YEAR 94		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH Deale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 522 Deale Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Housewife			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md. 13b. COUNTY AA 13c. CITY OR TOWN Deale						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 522 Deale Rd.			
14. FATHER'S NAME FIRST ALBERT MIDDLE WALKER LAST WALKER				15. MOTHER'S MAIDEN NAME FIRST SALLY MIDDLE COLE LAST COLE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-12-5223		17. INFORMANT ADDRESS WILLIAM E. WELCH SAME AS 13 E							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 4 April 19 83		CITY OR TOWN 29 Feb 19 84		COUNTY 19 84		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4 April 19 83 to 29 Feb 19 84 that (I) (we) lost saw the deceased alive on 4 April 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William P. Jones				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1 Mar 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. Jones, MD				22e. ADDRESS 645 America Ct. Davidsonville							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-3-84		23c. NAME OF CEMETERY OR CREMATORY DAVIDSONVILLE METHODIST CHURCH CEMETERY		23d. LOCATION CITY OR TOWN DAVIDSONVILLE		COUNTY ANNE ARUN-		STATE MD.	
24. FUNERAL DIRECTOR ROBERT E. EVANS ANNAPOLIS, MARYLAND				25a. DATE REC'D. BY REGISTRAR MAR 06 1984		25b. REGISTERED John Davidson-Randall					

BP

UNITED STATES
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : SAC, NEW YORK (100-100000)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 03278				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 02 09 84 2b. HOUR 10 ⁴⁰ P.M.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRIET (NMN) WELLS									
3. SEX F FEMALE		4. RACE B BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 22 00		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 2 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH EDGEWATER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Conv Ctr		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY VPG		13c. CITY OR TOWN OXON HILL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5401 Woodland Blvd			
14. FATHER'S NAME FIRST MIDDLE LAST BRYANT BOSTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HINES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO 435-04-4009		17. INFORMANT ADDRESS -D7, PERCY M. FLOWERS, OXON HILL, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 HYPERTENSION								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular Accident									
DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIAL Hemorrhage									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 22 82, 19 82, to FEBRUARY 09 84, 19 84, that (I) (we) lost the deceased alive on FEBRUARY 08 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles W. Kinzer DEGREE								22c. DATE SIGNED 2/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. KINZER				22e. ADDRESS 16 MURRAY AVE. ANNAPOLIS, MD 21401					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 02/16/84		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION CITY OR TOWN Whittier, COUNTY CA. STATE			
24. FUNERAL DIRECTOR NAME LEE FUNERAL HOME, INC. 6633 OLD ALEXANDER FERRY RD. CLINTON, MARYLAND				25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BRANT

Charles

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not at work," any injury, or other traumatic event, the medical examiner must be notified and advised.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03279			
1. DECEASED NAME (Last, first, middle) Eldridge S Wilkerson				2a. DATE OF DEATH MONTH DAY YEAR 2/15/84		2b. HOUR 4A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 18 1911		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Tracy's Landing		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 6007 Solomons Island Road		12a. USUAL OCCUPATION ret. co. unity emp.		12b. KIND OF BUSINESS OR INDUSTRY assessor	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? Maryland Anne Arundel Tracy's Landing YES				14. 6007 Solomons Island Rd. 20779			
14. FATHER'S NAME MIDDLE Eldridge Wilkerson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Iva Sherbert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. N7A 214 38 0334		17. INFORMANT ADDRESS Katherine Wilkerson same as #13			
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerosis 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____							
19a. DATE OF OPERATION 2/15/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carotid endarterectomy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Not an accident			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Lothian, Maryland			
22. I certify that (I) (this hospital) attended the deceased from 2/15/84 to 2/15/84 , that (I) (we) last saw the deceased alive on 2/15/84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death, so state.)							
22a. SIGNATURE Charles H. Wirth MD		22b. PHYSICIAN'S NAME (TYPE OR PRINT) Charles H. Wirth MD		22c. DATE SIGNED 2/15/84		22d. ADDRESS Lothian, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/19/84		23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		23d. LOCATION Friendship A.A. Maryland	
24. FUNERAL DIRECTOR NAME Rausch Funeral Home				25a. DATE REC'D. BY REGISTRAR FEB 21 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	



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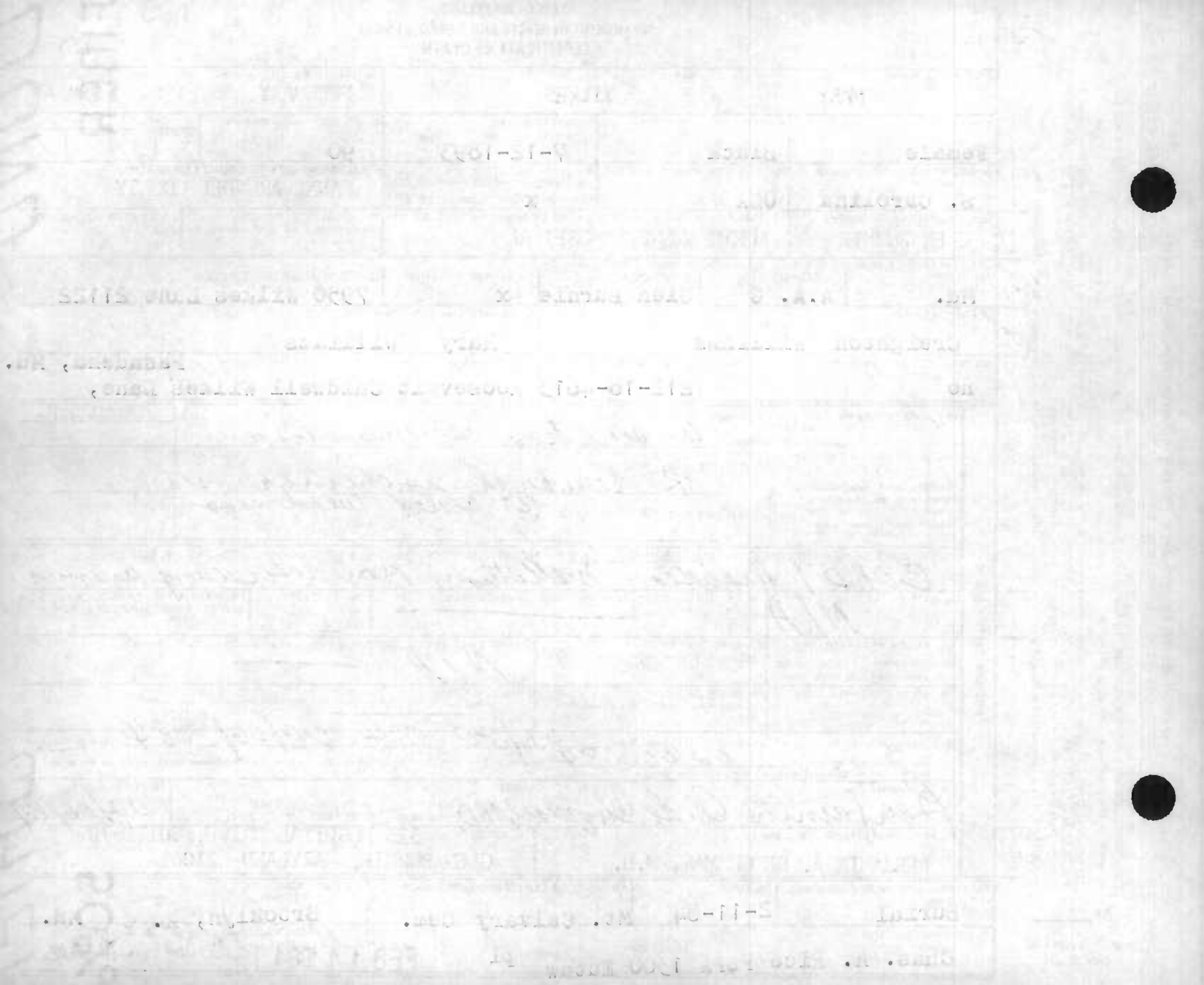
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.		EST	
1. FOR STATE REGISTRAR				2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY W WILKES				MONTH DAY YEAR FEBRUARY 6, 1984		550 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7-12-1893		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE	
13a. STATE Md.		13b. COUNTY A.A. C		13c. CITY OR TOWN Glen Burnie		13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7950 Wilkes Lane 21122	
14. FATHER'S NAME FIRST MIDDLE LAST Creighton Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 212-18-4813		17. INFORMANT ADDRESS Pasadena, Md. Roosevelt Caldwell Wilkes Lane,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia 4371 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral ischemia with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) 2 sided weakness (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD; Diabetes mellitus; Iron deficiency anemia							
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) N/A			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 01/20/84 to 02/06/84 , that (I) (we) lost saw the deceased alive on 02/06/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Benjamin A. de Guzman, M.D.				DEGREE M.D.		22c. DATE SIGNED 02/06/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN A. DE GUZMAN, M.D.				22e. ADDRESS 325 HOSPITAL DRIVE, SUITE 108 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-11-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn, A. C Md.	
24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 Eutaw				ADDRESS pl		25a. DATE REC'D. BY REGISTRAR FEB 14 1984	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

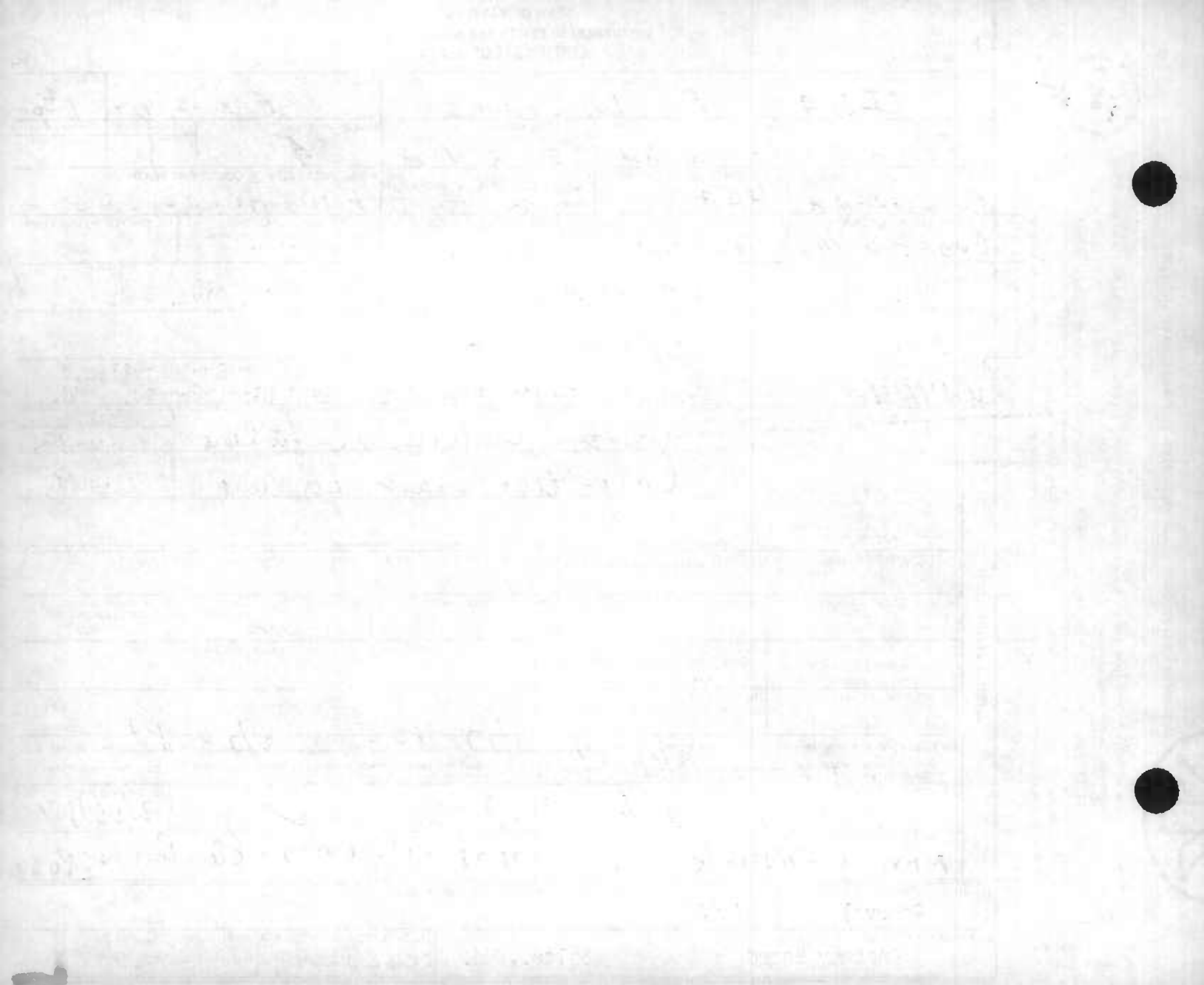
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 3 2 8 1

1. FOR STATE REGISTRAR		REG. NO.		M	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IDA P. WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR FEB 26, 1984		2b. HOUR 1:45 PM
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 3 2 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CROFTON CONV. CENTER			12. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY NIMMICK		13c. CITY OR TOWN Silver Spring
14. FATHER'S NAME FIRST MIDDLE LAST JACOB PINNAS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No		17. INFORMANT ADDRESS Burtonsville, Md. Ms. June Vinton 3904 Blackburn Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left ventricular failure</u> 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> (c) <u>Myocardial infarction</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/26/84</u> to <u>2/26/84</u> , that (I) (we) last saw the deceased alive on <u>2/26/84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Max C Frank MD</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/26/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX C FRANK MD		22e. ADDRESS <u>7575 Rickenbacker Hwy - Glen Burnie MD 21061</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/26/84		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR FEB 28 1984			
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25b. REGISTRAR'S SIGNATURE <u>Wardson-Randall</u>	

MEDICAL CERTIFICATION



DHMH - 17
(VR A15 ME (5))
20M 4/82

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03283			
1. FOR STATE REGISTRAR				1. DECEASED NAME FIRST MIDDLE LAST MATTIE WINDSOR			
2a. DATE OF DEATH MONTH DAY YEAR FEB. 14, 1984				2b. HOUR 10:10A.			
3 SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 21, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNAPOLIS CONVALESCENT CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS	
14. FATHER'S NAME FIRST MIDDLE LAST THEODORE BURGESS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HENRIETTA RODGERS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-54-9856		17. INFORMANT ADDRESS GENEVIEVE G. WINDSOR SAME AS 13E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 YRS. 15 YRS.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-12</u> , 19 <u>76</u> , to <u>2-14</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2-1</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN Edward S. Beck, M.D.				22c. DATE SIGNED 2/16/84		22d. ADDRESS EDWARD S. BECK, M.D. 1616 FOREST DRIVE ANNAPOLIS, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-16-83		23c. NAME OF CEMETERY OR CREMATORY HILLCREST CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS ANNE ARUNDEL CO	
24. FUNERAL DIRECTOR NAME ROBERT E. EVANS 1212 WEST ST. ANNAPOLIS				25a. DATE REC'D. BY REGISTRAR FEB 22 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

FEB 5 3 08 PM '84

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EARL Lyle WITT Sr.		2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 23, 1984		2b. HOUR M 510 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1908	
6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY		10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Printer and Linotype Oper.		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 408 Hillview Drive, 21090	
13a. STATE Maryland		13b. COUNTY A.A. Co.		13c. CITY OR TOWN Linthicum	
14. FATHER'S NAME FIRST MIDDLE LAST Luthen Witt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	
17. INFORMANT William J. Witt, Sr.		18. SOCIAL SECURITY NO. 216-10-3731		19. ADDRESS Reisterstown, Md. 21136 246 High Falcon Rd.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Jose M. Presbitero M.D.		DEGREE		22c. DATE SIGNED 2/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSE M. PRESBITERO, M.D.		22e. ADDRESS 7845 OAKWOOD ROAD SUITE 107 GLEN BURNIE, MARYLAND 21061		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/27/1984		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.		24. FUNERAL DIRECTOR NAME McCully Funeral Homes ADDRESS 237 E. Patapsco Ave.,			
25a. DATE REG'D. BY REGISTRAR FEB 24 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called in at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Thomas Hardeman Wolking			2a. DATE OF DEATH MONTH DAY YEAR Feb. 11, 1984			2b. HOUR 4:40 AM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb 4, 1906		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7 UNDER 1 YEAR MONTHS DAYS 18	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD			
10 CITY OR TOWN OF DEATH Crownsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairfield Nursing Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b KIND OF BUSINESS OR INDUSTRY Appliance Co	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b COUNTY AA		13c CITY OR TOWN Riva		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 128 Woodside Rd. 21140	
14 FATHER'S NAME FIRST MIDDLE LAST Aloysius Wolking		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Hardeman		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 577-10-6879		17 INFORMANT ADDRESS Emily B. Wolking - #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4920 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic fibrocystic disease DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 years	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Senility									
19a DATE OF OPERATION May 24, 1973		19b CONDITION FOR WHICH OPERATION WAS PERFORMED 72				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED (IN CERTIFYING CAUSES OF DEATH?) YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (this hospital) attended the deceased from May 24, 1973 , to Feb 11, 1984 , that (I) (we) last saw the deceased alive on Feb 1, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22a SIGNATURE Charles W. Kinzer				DEGREE ATTENDING PHYSICIAN				22c. DATE SIGNED Feb 13, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. KINZER, M.D.				22e ADDRESS ANNAPOLIS, MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Feb 13, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD			
24 FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD				25. DATE REC'D BY REGISTRAR FEB 15 1984		25b REGISTRAR'S SIGNATURE Judy Davidson-Randall			

Q. 1. What is the name of the person who
was with you on the night of the 1st of
January 1961? A. I don't know.
Q. 2. What is the name of the person who
was with you on the night of the 2nd of
January 1961? A. I don't know.
Q. 3. What is the name of the person who
was with you on the night of the 3rd of
January 1961? A. I don't know.
Q. 4. What is the name of the person who
was with you on the night of the 4th of
January 1961? A. I don't know.
Q. 5. What is the name of the person who
was with you on the night of the 5th of
January 1961? A. I don't know.

Q. 6. What is the name of the person who
was with you on the night of the 6th of
January 1961? A. I don't know.
Q. 7. What is the name of the person who
was with you on the night of the 7th of
January 1961? A. I don't know.
Q. 8. What is the name of the person who
was with you on the night of the 8th of
January 1961? A. I don't know.
Q. 9. What is the name of the person who
was with you on the night of the 9th of
January 1961? A. I don't know.
Q. 10. What is the name of the person who
was with you on the night of the 10th of
January 1961? A. I don't know.

Q. 11. What is the name of the person who
was with you on the night of the 11th of
January 1961? A. I don't know.
Q. 12. What is the name of the person who
was with you on the night of the 12th of
January 1961? A. I don't know.
Q. 13. What is the name of the person who
was with you on the night of the 13th of
January 1961? A. I don't know.
Q. 14. What is the name of the person who
was with you on the night of the 14th of
January 1961? A. I don't know.
Q. 15. What is the name of the person who
was with you on the night of the 15th of
January 1961? A. I don't know.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

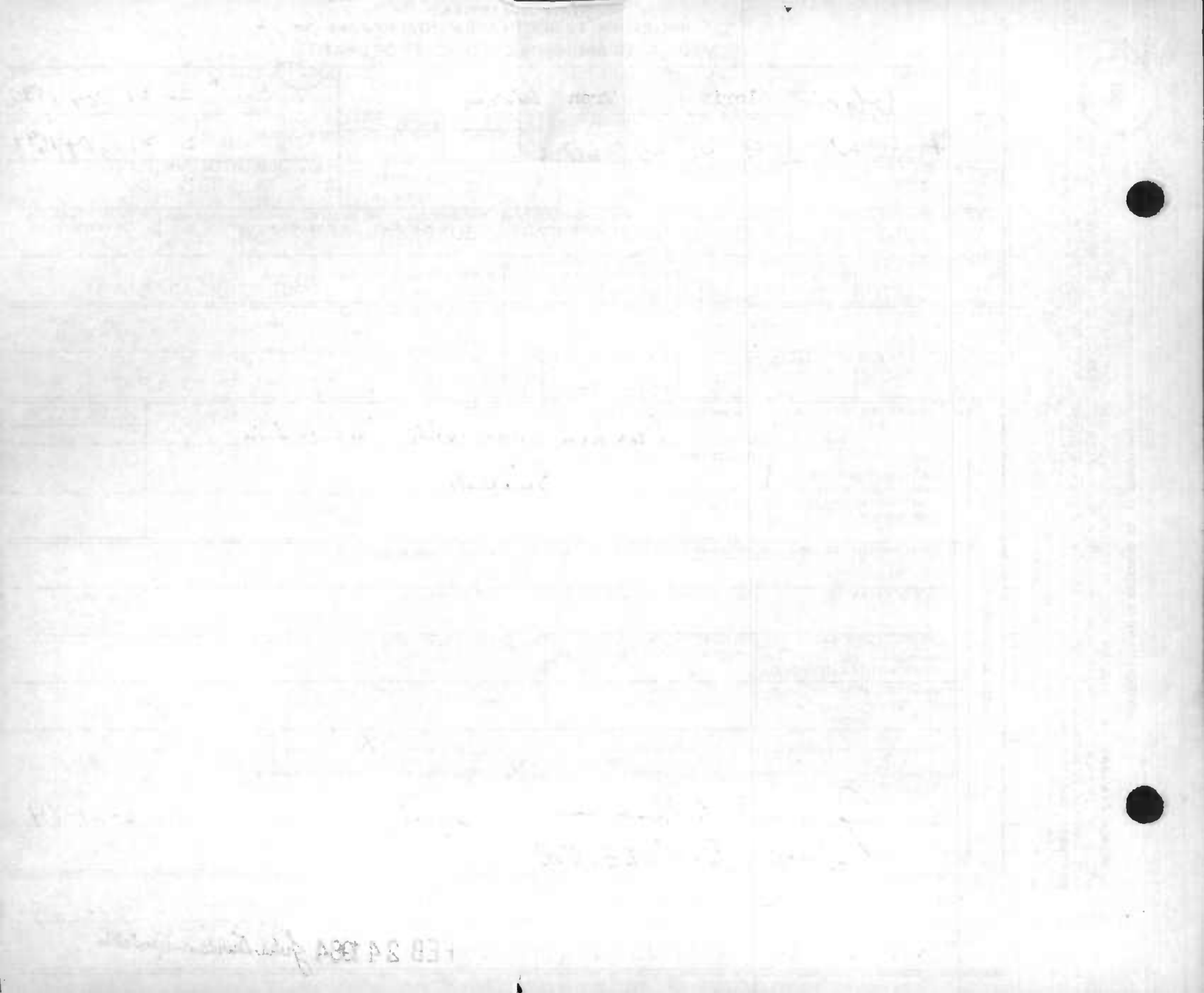
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DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR										84 03286									
1 DECEASED NAME (TYPE OR PRINT) Gloria Gloria B. Wren Wren										2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 2 DAY 21 YEAR 1984									
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH 4 DAY 29 YEAR 23		6 AGE (IN YEARS LAST BIRTHDAY) 60 RS.		IF UNDER 1 YR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c DATE PRONOUNCED DEAD MONTH 2 DAY 21 YEAR 1984		2d HOUR 1530 M					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO. MD.							
10 CITY OR TOWN OF DEATH ANNAPOLIS				11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK) HOMEMAKER				12b KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a STATE MARYLAND		13b COUNTY ANNE ARUNDEL		13c CITY OR TOWN ANNAPOLIS		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 3 RITCHIE ROAD 21401											
14 FATHER'S NAME FIRST LEONARD MIDDLE T. LAST BURTON				15 MOTHER'S MAIDEN NAME FIRST MARY MIDDLE FRANCES LAST CARSON															
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 451-26-0516		17 INFORMANT ADDRESS DONALD B. WREN SAME AS 13 E													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide inhalation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: 9520 Suicide (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)																			
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE James E. Wheeler				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 2-21-84							
EXAMINER'S NAME (TYPE OR PRINT) JAMES E. WHEELER				ADDRESS															
23a BURIAL, CREMATION, REMOVAL (15) CREMATION				23b DATE 2-27-84		23c NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMATORY				23d LOCATION CITY OR TOWN BRENTWOOD PR. GEO. COUNTY Md. STATE									
24 FUNERAL DIRECTOR NAME ROBERT E. EVANS ADDRESS ANNAPOLIS, MARYLAND				25a DATE REC'D BY REGISTRAR FEB 24 1984				25b REGISTRAR'S SIGNATURE Julia Davidson-Rendell											



FEB 24 1984